APS Healthcare

Final Report

CAEQRO Report, FY11-12

San Diego

Conducted on

February 22-24, 2012

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❖INTRODUCTION❖

BACKGROUND AND METHODOLOGY

The California Department of Mental Health (DMH) is charged with the responsibility of evaluating the quality of specialty mental health services provided to beneficiaries enrolled in the Medi-Cal managed mental health care program.

This report presents the fiscal year 2011-12 (FY11-12) findings of an external quality review of the San Diego County mental health plan (MHP) by the California External Quality Review Organization (CAEQRO), a division of APS Healthcare, from February 22-24, 2012.

The CAEQRO review draws upon prior year's findings, including sustained strengths, opportunities for improvement, and actions in response to recommendations. Other findings in this report include:

- Changes, progress, or milestones in the MHP's approach to performance management – emphasizing utilization of data, specific reports, and activities designed to manage and improve quality.
- Ratings for Key Components associated with the four domains: quality, access, timeliness, and outcomes. Submitted documentation as well as interviews with a variety of key staff, contracted providers, advisory groups and other stakeholders serve to inform the evaluation within these domains. Detailed definitions for each of the review criterion can be found on the CAEQRO Website www.caeqro.com
- Analysis of Medi-Cal Approved Claims data
- Two active Performance Improvement Projects (PIPs) – one clinical and one non-clinical
- Three 90-minute focus groups with beneficiaries and family members
- Information Systems Capabilities Assessment (ISCA) V7.2

❖FY11-12 REVIEW FINDINGS❖

STATUS OF FY10-11 REVIEW RECOMMENDATIONS

In the FY10-11 site review report, CAEQRO made a number of recommendations for improvements in the MHP's programmatic and/or operational areas. During this year's FY11-12 site visit, CAEQRO and MHP staff discussed the status of those FY10-11 recommendations, which are summarized below.

ASSIGNMENT OF RATINGS

- Fully addressed – The issue may still require ongoing attention and improvement, but activities may reflect that the MHP has either:
  - resolved the identified issue
  - initiated strategies over the past year that suggest the MHP is nearing resolution or significant improvement
  - accomplished as much as the organization could reasonably do in the last year

- Partially addressed – Though not fully addressed, this rating reflects that the MHP has either:
  - made clear plans and is in the early stages of initiating activities to address the recommendation
  - addressed some but not all aspects of the recommendation or related issues

- Not addressed – The MHP performed no meaningful activities to address the recommendation or associated issues.

KEY RECOMMENDATIONS FROM FY10-11

- Develop processes of communication and outreach to educate consumers and family members of existing methods/forums for collecting input and involving them in system planning and evaluation:

  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  While the MHP already had many existing forums for input and involvement in system planning and evaluation, the MHP undertook strategies to outreach to consumers and family members to heighten overall awareness of these input opportunities:

- The MHP made increased use of Recovery Innovation of California (RICA) liaisons. Liaisons attend both administrative planning meetings, and facilitate regional, community-based consumer/family member meetings, thereby strengthening the feedback loop between the two contingents.
- The Common Ground approach, a decision support intervention created by Pat Deegan, is being implemented, with trainings facilitated by peers. The Common Ground approach supports consumers and family members in functioning effectively as self-advocates with their providers.
- The MHP conducted numerous focus groups including one for Full Service Partner (FSP) consumers to poll satisfaction with their housing services, and to garner input regarding the physical plants and service designs for MHSA permanent supported housing.
- The MHP conducted seven "experience of treatment" focus groups with groups of adults consumers (four), caregivers of minor children (two), and youth (one). These focus groups specifically targeted identifying areas of dissatisfaction with services. Findings of these focus groups are reported in greater detail later in this report.
- The MHP maintains several Quality Advisory Councils (such as the Cultural Competence Resource Team and the Quality Review Council) that have consumer and family member representation. At the request of the Quality Review Council (QRC), the MHP posts meetings that offer opportunity for consumer and family member input on the Network of Care website calendar.
- Adult Mental Health Services (AMHS) require Program Advisory Councils (PAG) composed of 51% consumers to exist in all outpatient services (currently totaling approximately 40 PAGs). The Children's Family Youth Roundtable (Roundtable) is assisting the formation of PAGs in the Children's System of Care (CSOC).
- RICA publishes "Peers Linking Peers", a newsletter that is reportedly distributed widely. Editions from 2011 (no current editions) are found on the Network of Care website.

- Develop routine processes for measurement, review, and performance improvement of timeliness to psychiatry appointments for children, timeliness to appointments following hospital discharge, urgent appointments, and no shows. Establish a minimum standard for timeliness to psychiatric and urgent appointments:

☐ Fully addressed ☒ Partially addressed ☐ Not addressed

- The MHP is working with Optum Health to develop a report capturing wait times post-psychiatric hospital discharge.
- The MHP currently has the capability to track no shows, but has not established a consistent process for ongoing monitoring.
- The MHP has chosen to defer timeliness tracking for children's psychiatry appointments and timeliness to urgent services until electronic tracking capability of those elements is implemented in the Information System (IS). The MHP maintains

that manually tracking these data elements would be overly burdensome on both contracted and directly operated programs.

- The MHP initiated a survey with 200 contract providers to gather estimated within-agency timeliness to urgent conditions response and to post-hospitalization follow up appointments. 85 surveys were returned. The compilation of this anecdotal information reports the following results:
  - 88% of consumers requesting urgent assessments/contacts received them in less than 72 hours, with 14% of children and 4% of adults waiting over 72 hours for a contact.
  - 74% of post-hospitalization clients were seen within 72 hours, with the range being 68% (children's programs) to 88% (adult's programs).
  - Estimated wait times to assessment and wait times to follow up post-crisis residential were also surveyed.

- Complete the planning process to automate dashboard indicator reports and develop the business processes to implement the production process:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - The MHP has determined that automation of the monthly dashboard report production is not technically feasible due to the difficulty of merging data from diverse sources.
  - Current dashboard reports are distributed within one to two months, which the MHP finds adequate for Quality Improvement (QI) and administrative purposes.
  - Critical reports are generated and distributed daily. Other reports are produced on an ad hoc basis.

- Address the significant Medi-Cal revenue shortfall caused by not being current with claims submissions for FY10-11:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

  - All issues encountered during the Short//Doyle Phase II implementation were resolved and the MHP reports no shortfall for FY10-11.
  - Although FY11-12 claims were initially withheld by the MHP while taxonomy code issues were resolved with the State, claiming is current and submitted in a timely manner.

- Work with the Anasazi California User Group, CMHDA, and the State DMH and DHCS to implement HIPAA 5010 transaction code sets prior to January 1, 2012:
  ☒ Fully addressed ☐ Partially addressed ☐ Not addressed

- The MHP has implemented the 5010 transaction code set in Anasazi, but has not been able to complete testing due to processing delays by the State.
- The MHP is confident that they will be able to meet the extended deadline for completing the conversion.
- The Administrative Services Manager is Vice Chair of the Anasazi Users Group and the MHP has staff participants in nearly all sub-groups.

CHANGES IN THE MHP ENVIRONMENT AND WITHIN THE MHP

Changes since the last CAEQRO review, identified as having a significant effect on service provision or management of those services are discussed below. This section emphasizes systemic changes that affect access, timeliness, quality, and outcomes, including those changes that provide context to areas discussed later in this report.

- The MHP is undergoing personnel changes at the upper management level. The CSOC is headed by a new Assistant Deputy Director who has developed a new multi-year strategic plan for the CSOC. The Behavioral Health Services Division Director has announced her retirement effective May 2012.
- The MHP began implementing AB109 in October 2011 to provide treatment services for the parolee population. Behavioral Health Screening Teams, consisting of a mental health clinician and an alcohol and drug specialist, are co-located at several Probation sites to provide screening and linkage services. By early January 2012, approximately one third of released parolees had been referred for behavioral health (BH) services. Further details are provided later in this report.
- The MHP continues to participate in "Live Well San Diego!" a ten-year, county-wide effort initiated in 2008. "Live Well San Diego!" focuses on creating a county-wide community that is "safe, healthy and thriving". The first of three strategic initiatives, Building Better Health, is built on the 3-4-50 concept: targeting "three behaviors: lack of exercise, poor diet and tobacco use, that lead to four diseases: cancer, heart disease, type 2 diabetes and lung disease, that lead to over 50% of all deaths." Three ongoing MHP initiatives that fall under this effort are: the behavioral health Initiative, implementing electronic health records, and integrating physical health care for adults.
- The MHP is participating in the implementation of Low Income Health Plan (LIHP) that provides integrated medical and behavioral health services for qualifying individuals. BH benefits under this plan are defined as twelve outpatient encounters and ten days of acute inpatient hospitalization per year, plus a psychiatric medications benefit. The County has enrolled approximately 75% of its 22,000 target enrollment.

- Using Prevention and Early Intervention (PEI) funds, the MHP launched an extensive stigma reduction and suicide prevention media campaign called "Its Up to Us San Diego". Further description follows in the Performance Improvement Project Validation section.
- The MHP is involved in a major housing initiative in conjunction with the California Housing Finance Authority (Cal HFA). Eleven projects have been planned and nine have received approval, totaling 191 units of permanent supportive housing. Some projects are finished and fully leased.
- The media campaign "Housing Matters: Mental Illness Stigma and Housing Discrimination Reduction Campaign" concluded this year with an evaluation showing an increase in general public understanding of (11% increase) and acceptance for supportive housing to end homelessness. At the conclusion of the campaign, 71% of San Diegans endorsed the statement they would be willing to have supportive housed within one half mile of their place of residence, which increases from 64% at baseline.
- As an alternative to implementing Laura's Law, the MHP created the In-Home Outreach Teams (IHOT) to bring services to those who need treatment, but are reluctant to seek services. Additionally, the MHP has analyzed the array of services it provides and organized them into a BH "Toolkit," identifying programs along a scale of intensity of care by name, provider and description, along with as limitations (e.g., access, capacity, mode of service delivery) by program.
- The MHP has entered into a Memorandum of Understanding (MOU) with the six Special Education Local Plan Areas (SELPA) for the transition from AB3632 to AB2726 Educationally Related Mental Health Services (ERMHS) in FY11-12. The MHP has bid on a Request for Proposals (RFP) to provide services beyond FY11-12 and is awaiting the outcome. The MHP projects that 22 designated positions would be impacted by the outcome of the RFP.
- The Family and Youth Roundtable is the official training academy for family partners. During the past review period, the Roundtable developed a "train-the-trainer" program for San Diego County and was hired by the state of Mississippi to train their staff. Mississippi has reportedly successfully implemented the program, and other states including Tennessee, Ohio, and North Dakota are reportedly considering the same approach.

PERFORMANCE & QUALITY MANAGEMENT KEY COMPONENTS

CAEQRO's overarching principle for review emphasizes the MHP's use of data to promote quality and improve performance. Components widely recognized as critical to successful performance management – an organizational culture with focused leadership and strong stakeholder involvement, effective use of data to drive quality management, a comprehensive service delivery system, and workforce development strategies which support system needs – are discussed below.

Quality

CAEQRO identifies the following components of an organization that is dedicated to the overall quality services. Effective quality improvement activities and data-driven decision making requires strong collaboration among staff, including consumer/family member staff, working in information systems, data analysis, executive management and program leadership. Technology infrastructure, effective business processes, and staff skills in extracting and utilizing data for analysis must be present in order to demonstrate that analytic findings are used to ensure overall quality of the service delivery system and organizational operations.

Figure 1. Quality

Component		Present	Partial	Not Present	Not Rated
1A	Quality management and performance improvement are organizational priorities	X			
1B	Data is used to inform management and guide decisions	X			
1C	Investment in information technology infrastructure is a priority	X			
1D	Integrity of Medi-Cal claim process, including determination of beneficiary eligibility and timely claims submission	X			
1E	Effective communication from MHP administration	X			
1F	Stakeholder input and involvement in system planning and implementation	X			
1G	Consumers and family members are employed in key roles throughout the system	X			

Issues associated with the components identified above include:

- The MHP has a FY11-12 QI Work Plan with measurable goals and objectives, and an annual evaluation of FY10-11 activities and indicators. The MHP has a functional Quality Review Council (QRC). The MHP submitted minutes for the six QRC meetings that occurred in 2011.
- The QI Director (QID) developed a Program Evaluation Plan outlining a decision-making process using a combination of qualitative and quantitative methods including consumer and family member input for making recommendations to the Mental Health Director (MHD) and the Mental Health Board (MHB) regarding program reductions and/or closures/redesigns as needed in response to budgetary shortfalls. The QID labeled this strategy "economic reality planning."
- The MHP makes extensive use of data to inform management and guide decisions. The MHP monitors quality indicators, consumer outcomes, measures progress towards goals, and reports findings for review.
- The MHP continues to contract with UCSD Child and Adolescent Services Research Center (CASRC) and the UCSD Health Services Research Center (HSRC) for data reporting and analysis support.
- The MHP has allocated adequate funding to complete the EHR implementation and for a number of additional projects.
- Telepsychiatry is used extensively at both county-run and contracted sites. MHP staff and contractors have access to documents and data via the intranet.
- The MHP and contracted vendors supply sufficient resources for IS implementation, training, system management, and support.
- The MHP provides timely training for software implementation, new users and refresher needs.
- Polices and procedures are comprehensive, up-to-date and accessible. The Financial Manual is being revised to be more user friendly.
- Current claims volume is in line with previous years.
- Although claims submissions were withheld for several months earlier in this year for resolution of technical issues, the MHP is current with submissions and error correction.
- Line staff felt they did not have adequate opportunity to provide input into critical decisions, citing, for example, the movement towards a short term treatment model (13 sessions).

- Contract agencies each have Contracting Officer's Technical Representatives (COTR) through whom communication and feedback can be exchanged. There are multiple meetings including the monthly Case Management Provider meeting, the Regional Providers meeting and the Quarterly Leadership meeting chaired by the MHP Director. Additionally, many of the contractors belong to San Diego's Mental Health Contractors Association.
- Each Adult/Older Adult outpatient program is required to maintain a Program Advisory Group (PAG), a body comprised of a minimum of 51% consumer/family members. These groups provide opportunity for ongoing consumer/family feedback and communication. RICA liaisons assist in training PAG members in roles and responsibilities in new programs and provide technical assistance as needed.
- The MHP is investigating implementing additional strategies for enhancing communication between staff involved in consumer care and the consumers. A short term pilot of Pat Deegan's Common Ground, a proprietary web-based program to promote Shared Decision Making is in place in one of the Assertive Community Treatment (ACT) teams. The MHP plans to implement Common Ground in all the ACTs in the coming year.
- The MHP employs consumers and family members through Recovery Innovations of California (RICA). Peers reported variance between agencies with regard to the value placed on peer roles, as well as the ability to receive formal support for their roles. Some peers reported being prevented by their agencies from participating in groups that provide support to peer employees because of concerns around productivity. Multiple stakeholders stated that peer and family member positions tended to lack clear role definitions, which created difficulties for both the consumer/family member staff and clinical staff.
- The MHP instituted an innovative new program, Hope Connections, that incorporates peer and family partners to assist consumers in bridging from inpatient to outpatient services, as well as offers support during other significant life transitions.
- Consumer and Family Member leaders are included in executive management team meetings.

Access

CAEQRO identifies the following components as representative of a broad service delivery system which provides access to consumers and family members. Examining capacity, penetrations rates, cultural competency, integration and collaboration of services with other providers form the foundation of access to and delivery of quality services.

Figure 2. Access					
Component		Present	Partial	Not Present	Not Rated
2A	Service accessibility and availability are reflective of cultural competence principles and practices	X			
2B	Manages and adapts its capacity to meet beneficiary service needs	X			
2C	Penetration Rates are used to monitor and improve access	X			
2D	Integration and/or collaboration with community based services	X			

Issues associated with the components identified above include:

- The MHP assesses the cultural, ethnic, racial, and linguistic needs of its eligibles, and implements strategies to address the needs of eligibles. The MHP provides services in five threshold languages: English, Spanish, Tagalog, Vietnamese and Arabic, and tracks the needs of emergency ethnic/linguistic populations, as well as populations with unique treatment needs, such as veterans and other trauma-exposed populations.
- The MHP continues with its redesigned access to urgent services strategy, having moved from providing centralized services at the Emergency Psychiatric Unit (EPU) to regionalized Urgent Walk-In services. Multiple walk-in providers exist in each region, and consumers are directed to clinics by zip code. This strategy is meant to not only make urgent services more accessible and timely, but to also forge a stronger treatment relationship with routine outpatient clinics, thereby decreasing reliance on emergency services.
- The MHP has implemented short-term and evidence-based treatment models in both adult and children's services in an effort to increase treatment efficacy and system capacity.
- The MHP used the California Brief Multi-Cultural Survey to obtain a baseline measurement of program staff's cultural competency. From 175 agencies, 1875 clinicians completed the instrument. Competencies and training needs were identified and reported out by program.
- The MHP is implementing a Cultural Competence Academy—an intensive skill based educational and training opportunity focused on raising staff cultural competency and improving service delivery to consumers from diverse racial/ethnic backgrounds.

- The MHP continued distribution of the fotonovela "Salir Adelante" as printed pamphlets and in two popular Spanish language newspapers. An evaluation report conducted by the Metropolitan Group in collaboration with HSRC describes the impact of the fotonovela on 463 respondents. Reactions to the fotonovela were positive and indicated that it was a valuable tool in reducing mental health stigma as a barrier to seeking treatment.
- The MHP began implementation of AB 109 population in October 2011. The Implementation Plan includes provisions that: enhance pre-trial processes, streamline felony settlements, encourage alternative custody options and in-custody programming, and employ evidence-based practices (EBP) in sentencing, supervision and treatment. In first month, responsibility for 269 parolees transitioned to the responsibility of County Probation. MHP anticipates that by end of FY11-12, the combined post-release offender and N3 (non-violent, non-serious, non-sexually related crimes) population will reach 3,200. Projections are the 85% of this population will require substance abuse treatment and 20% will qualify for Specialty Mental Health services. Twenty-seven percent (27%) of the initial allocation realignment allocation was ear-marked for behavioral health services. The MHP is offering three levels of services: medications, recovery services, and Full Service Partner (FSP) services. The MHP is using the Addiction Severity Index (ASI) to determine needs in multiple life domains.
- The MHP continues with its history of integrated and collaborative relationships with community-based organizations. One example is the MHP's commitment to promoting behavioral health and physical healthcare integration using the shared "population management" strategy referred to as the "paired provider model". In this model, a seamless, bi-directional flow of patients and information is prioritized over physical co-location of services. This bi-directional flow is accomplished by pairing behavioral health and Federally Qualified Health Centers (FQHC)/primary care clinics, while using the ACE model: Access to Behavioral health services, Consultation to primary care, and Education for primary care providers. Referrals to behavioral health from primary care and dispositions are being tracked.

Timeliness

CAEQRO identifies the following components as necessary to support a full service delivery system that provides timely access to mental health services. The ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries throughout the system of care to full recovery.

Figure 3. Timeliness					
Component		Present	Partial	Not Present	Not Rated
3A	Tracks and trends access data from initial contact to first appointment	X			
3B	Tracks and trends access data from initial contact to first psychiatric appointment		X		
3C	Tracks and trends access data for timely appointments for urgent conditions			X	
3D	Tracks and trends timely access to follow up appointments after hospitalization.			X	
3E	Tracks and trends No Shows			X	

Issues associated with the components identified above include:

- The MHP maintains a standard of eight days from initial contact to first appointment in Adult Services. Average wait time is 2.9 days, with the average being 0.8 days for Fee for Service (FFS) and Emergency Psychiatric Unit (EPU). The standard for children's services is five days, and the average wait time is 5.2 days. The MHP states that wait times to subsequent appointments pose a greater challenge than initial wait times. Wait times are tracked and trended year over year from FY06-07 through the present. When wait times become lengthy, the MHP reportedly intervenes and mitigates the problem, for example, by utilizing locum tenens psychiatrists.
- The MHP tracks time to initial psychiatry appointment for adults, defined as "first contact until first offered service". The MHP does not maintain an official standard—unofficially the goal is seven days. Average wait time is 6.8 days, with the average for FFS and EPU being 1.7 days. The MHP does not currently track this indicator for children; citing 1) low numbers of children receiving medication services, 2) limited number of pediatric psychiatry doctor hours and 3) lack of necessary IS functionality. Once IS functionality is achieved, the MHP plans to track this indicator for all age cohorts. The MHP is currently engaged in long-range planning around psychiatry and telepsychiatry services. Wait times are tracked and trended year over year from FY06-07 through the present.
- The MHP does not currently track wait times for urgent conditions. QI maintains a goal of 72 hours and this standard is documented in the contract requirements in the Organizational Provider Handbook. Contract monitors oversee adherence to this standard. The MHP reports ongoing difficulty

collecting reliable data in this domain and has opted to wait until there is a better mechanism to collect this data electronically.

- The MHP does not maintain a seven day post hospital follow up standard. Organizational providers' handbook states that a consumer leaving the hospital is considered in urgent need of an appointment and should be seen within 72 hours. QI cites difficulty getting discharge notification from the hospitals and that the data is often unreliable. The MHP does conduct extensive tracking and analysis of 30-day rehospitalization rates across age groups as well as six month rehospitalization rates for children.
- The MHP did not provide evidence of tracking and trending No Show data. Procedures are not in place to ensure correct entry of No Shows/Cancellations at contract sites or to track findings through data analysis.

Outcomes

CAEQRO identifies the following components as essential elements of producing measurable outcomes for beneficiaries and the service delivery system. Evidence of consumer run programs, viable performance improvement projects, consumer satisfaction surveys and measuring functional outcomes are methods to evaluate the effectiveness of a service delivery system as well as identifying and promoting necessary improvement activities to increase overall quality and promote recovery for consumers and family members.

Figure 4. Outcomes

Component		Present	Partial	Not Present	Not Rated
4A	Consumer run and or consumer driven programs	X			
4B	Measures clinical and/or functional outcomes of consumers served	X			
4C	One active and ongoing clinical PIP	X			
4D	Clinical PIP shows post-intervention results	X			
4E	One active and ongoing non-clinical PIP	X			
4F	Non-Clinical PIP shows post-intervention results	X			

Figure 4. Outcomes					
Component		Present	Partial	Not Present	Not Rated
4G	Utilizes information from Consumer Satisfaction Surveys	X			

Issues associated with the components identified above include:

- The MHP has approximately 14 consumer run centers. Each has a PAG. CAEQRO reviewers visited The Corner Clubhouse (CC), located in central San Diego. The CC is open Monday through Friday from 8 a.m. to 4 p.m. with hours extended until 6 p.m. on Tuesday to accommodate those with work or volunteer obligations. Participants must have a current or lifetime history of mental illness. The CC offers a variety of activities to help members obtain educational, social, training, and work experiences which will enable them to integrate into the community. The calendar of activities is changed based on the needs and interests of active members. For the period from July through December 2011 total membership count was 765.
- Consumer advocates reported a lack of clear process for consumers who receive services from Fee for Service (FFS) providers to receive referral and linkage to Clubhouses and other resources once they have exhausted their service authorization.
- The MHP collects functional and clinical outcomes for children, adolescents, adults, older adults yearly and summarizes them in two system-wide annual reports. The report contains demographic breakdowns by age, gender, race/ethnicity, language preference, living situation, educational level, employment and insurance status, diagnosis (MH and substance abuse diagnoses), service utilization (including an in-depth look at emergency service and hospital utilization) and wait times to first routine mental health assessment and psychiatry service. Exploration of clinical outcomes includes measures of quality of life, and objective indicators such as encounters with law enforcement.
- To measure child and adolescent outcomes, the MHP uses the Child and Adolescent Needs and Strengths Scale (CANS), the Child and Adolescent Measurement System (CAMS), the Children's Functional Assessment Rating Scale (CFARS), inpatients readmission rates, and the Youth Services Survey (YSS).
- Adult outcomes are measured using a variety of instruments including the Milestones of Recovery Scale (MORS), Level of Care Utilization System

(LOCUS), the Illness Management and Recovery Scale (IMR), and the Recovery Markers Questionnaire (RMQ).

- The MHP has 13 child/adolescent FSP programs and 19 adult/older adult FSP programs. Assessments and quarterly reassessments are reported to the State DMH Data Collection Reporting System (DCR). The MHP is working to compile outcome reports by program.
- MHP reports that outcomes are routinely distributed to Program Managers, but that it is challenging to get findings back to clinical line staff and to consumers. It reports considering using the RICA newsletter to help disseminate outcomes.
- The MHP uses a wide variety of evidence based practices (EBP) and uses the Global Organization Index (GOI) to examine the system-wide quality of the EBP implementation and fidelity to model.
- The MHP submitted a clinical and a nonclinical PIP. Both had post-intervention results and were considered active for the review period but concluded PIPs, although the interventions and measurements will be ongoing.
- The MHP conducts twice yearly (November and May) consumer satisfaction surveys and trends the findings year over year. Surveys reveal a general pattern of high satisfaction and results remain relatively consistent year over year. Despite reported high satisfaction, the MHP is following a recommendation by the Mental Health Board (MHB) to undertake a Customer Service Quality Improvement Project. This project aims to explore what have historically been the top five customer service concerns: 1) changing access to services, 2) staff rudeness, 3) feelings that providers do not listen, 4) problems with medications and 5) lack of confidentiality in waiting rooms and elsewhere. The MHP is using the Plan Do Study Act (PDSA) model to bring about change in customer satisfaction. Seven "experience of treatment" focus groups, specifically targeting areas of dissatisfactions, were conducted by academic research partners in 2011. Thirty three consumers participated in total. Strategies to address areas of concern are being formulated.
- The MHP plans to establish an annual consumer report to disseminate information detailing how consumer input has been utilized to impact the system in the previous year.

❖CURRENT MEDI-CAL CLAIMS DATA FOR MANAGING SERVICES❖

Information to support the tables and graphs, labeled as Figures 5 through 18, is derived from four source files containing statewide data. A description of the source of data and summary reports of Medi-Cal approved claims data – overall, foster care, and transition age youth – follow as an attachment. It should be noted that significant claims lag may exist due to SD/MC Phase II processing issues. The claims lag varies across the MHPs. The MHP was also referred to the CAEQRO Website at www.caeqro.com for additional claims data useful for comparisons and analyses.

RACE/ETHNICITY OF MEDI-CAL ELIGIBLES AND BENEFICIARIES SERVED

The following figures show the ethnicities of Medi-Cal eligibles compared to those who received services in CY10. Charts which mirror each other would reflect equal access based upon ethnicity, in which the pool of beneficiaries served matches the Medi-Cal community at large.

Figure 5 shows the ethnic breakdown of Medi-Cal eligibles statewide, followed by those who received at least one mental health service in CY10. Figure 6 shows the same information for the MHP's eligibles and beneficiaries served. Similar figures for the foster care and TAY populations are included in Attachment D following the MHP's approved claims worksheets.

Figure 5a. Statewide Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY10

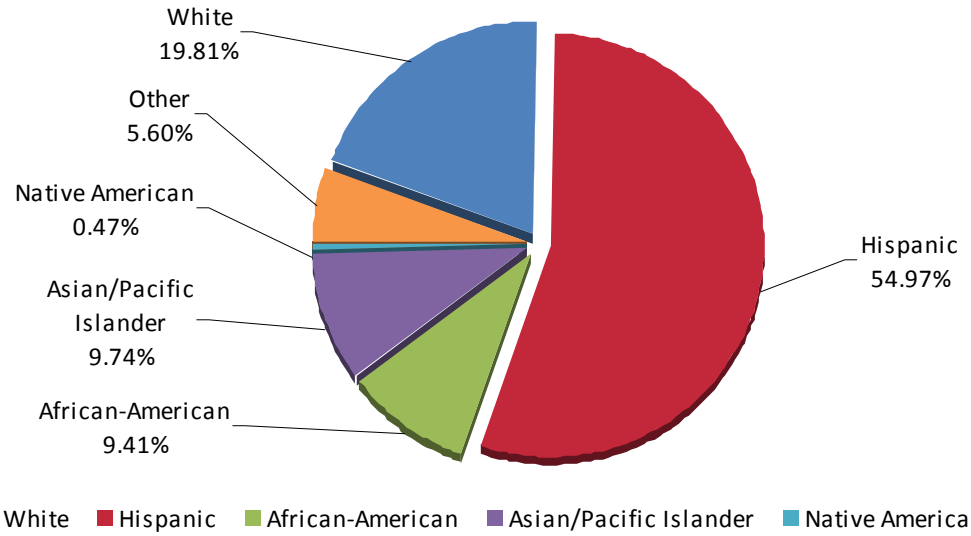


Figure 5b. Statewide Medi-Cal Beneficiaries Served, by Race/Ethnicity CY10

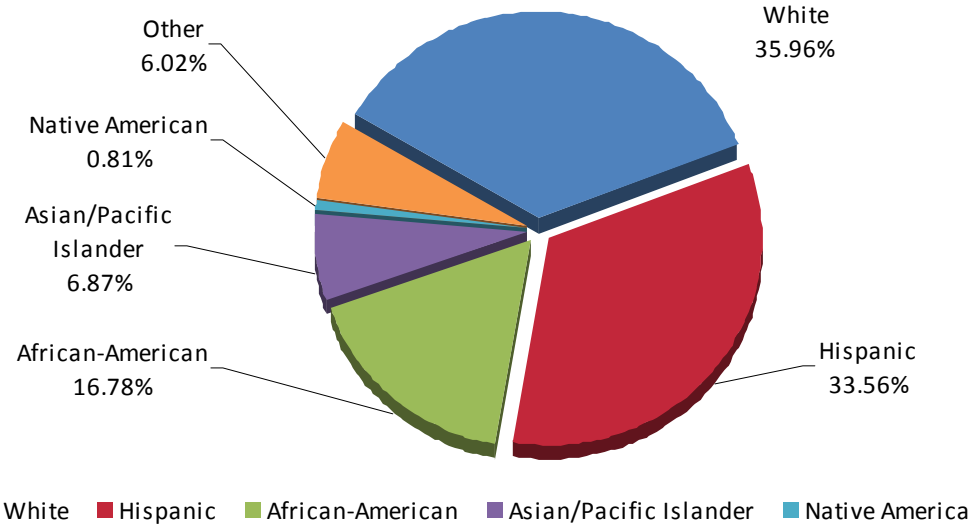


Figure 6a. MHP Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity CY10

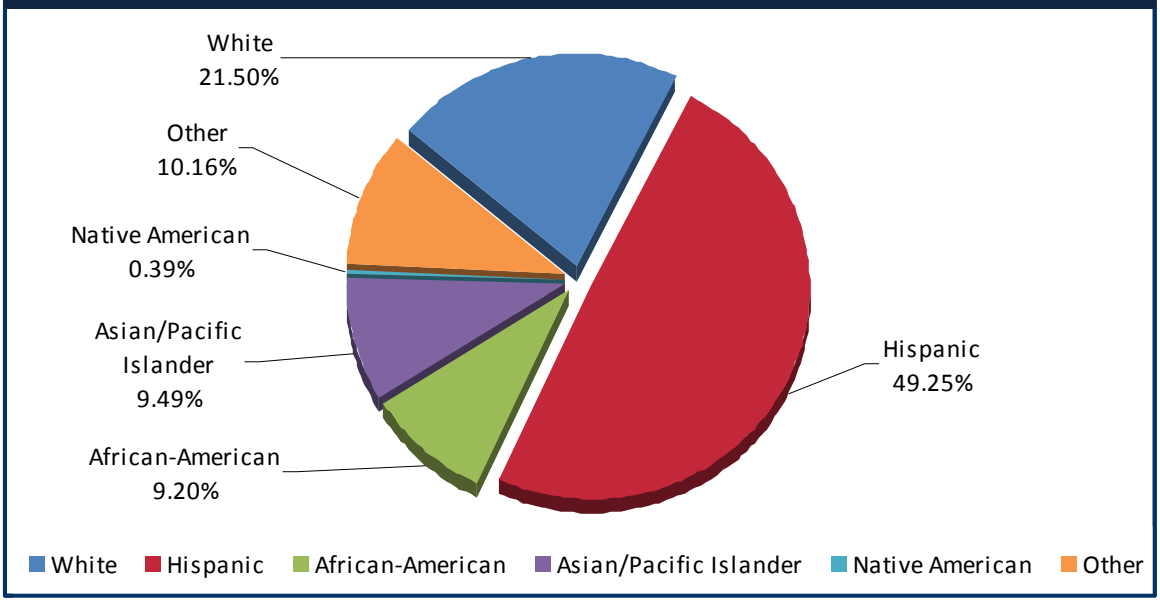
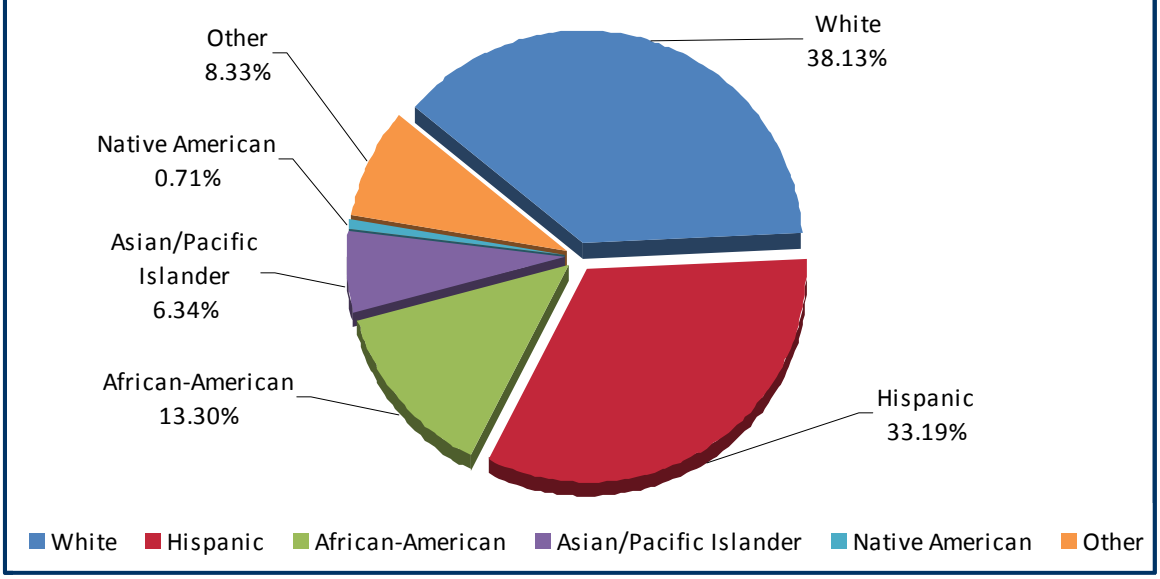


Figure 6b. MHP Medi-Cal Beneficiaries Served, by Race/Ethnicity CY10



PENETRATION RATES AND APPROVED CLAIM DOLLARS PER BENEFICIARY

The penetration rate is calculated by dividing the number of unduplicated beneficiaries served by the monthly average eligible count. The average approved claims per beneficiary served per year is calculated by dividing the total annual dollar amount of Medi-Cal approved claims by the unduplicated number of Medi-Cal beneficiaries served per year. Rankings, where included, are based upon 56 MHPs, where number 1 indicates the highest rate or dollar figure and number 56 indicates the lowest rate or dollar figure.

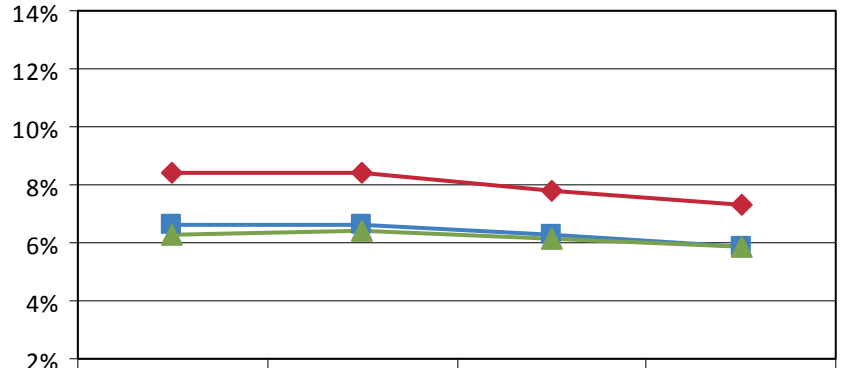
Figure 7 displays key elements from the approved claims reports for the MHP, MHPs of similar size (large, medium, small, or small-rural), and the state.

Figure 7. CY10 Medi-Cal Approved Claims Data

Element	MHP	Rank	Large MHPs	Statewide
Total approved claims	$94,223,185	N/A	N/A	$2,053,312,275
Average number of eligibles per month	409,838	N/A	N/A	7,478,296
Number of beneficiaries served	30,051	N/A	N/A	438,230
Penetration rate	7.33%	29	5.87%	5.86%
Approved claims per beneficiary Served	$3,135	45	$4,288	$4,685
Penetration rate – Foster care	70.84%	13	58.13%	62.53%
Approved claims per beneficiary served – Foster care	$6,336	27	$7,213	$7,514
Penetration rate – TAY	8.74%	26	6.99%	7.03%
Approved claims per beneficiary served – TAY	$4,506	31	$5,396	$5,792
Penetration rate – Hispanic	4.94%	17	3.51%	3.58%
Approved claims per beneficiary served – Hispanic	$3,108	39	$3,918	$4,446

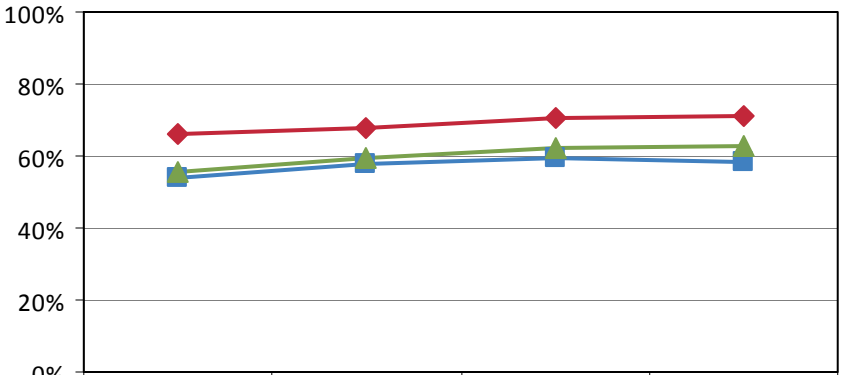
Figures 8 through 11 highlight four year trends for penetration rates and average approved claims.

Figure 8. Overall Penetration Rates CY07-CY10



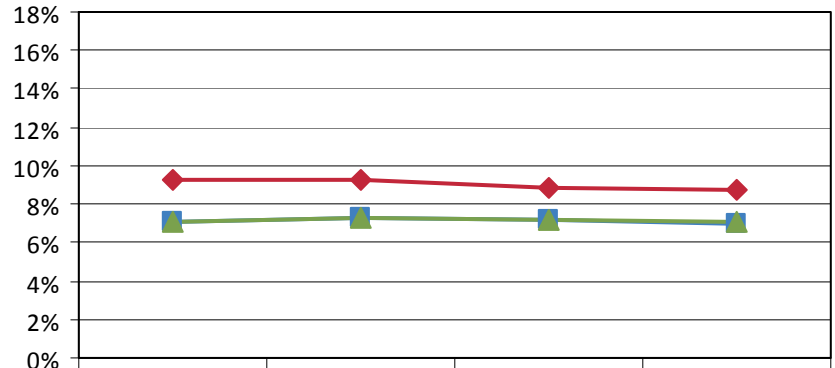
	CY07	CY08	CY09	CY10
MHP	8.42%	8.42%	7.78%	7.33%
Large MHPs	6.62%	6.63%	6.25%	5.87%
Statewide	6.29%	6.38%	6.15%	5.86%

Figure 9. Foster Care Penetration Rates CY07-CY10



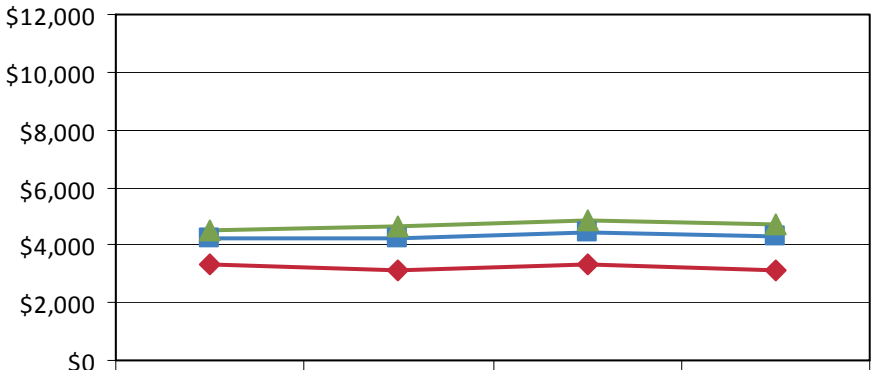
	CY07	CY08	CY09	CY10
MHP	66.33%	67.55%	70.41%	70.84%
Large MHPs	53.67%	57.96%	59.43%	58.13%
Statewide	55.82%	59.39%	62.43%	62.53%

Figure 10. Transition Age Youth Penetration Rates CY07-CY10



	CY07	CY08	CY09	CY10
MHP	9.28%	9.28%	8.82%	8.74%
Large MHPs	7.07%	7.29%	7.17%	6.99%
Statewide	7.05%	7.30%	7.21%	7.03%

Figure 11. Average Approved Claims per Beneficiary Served CY07-CY10



	CY07	CY08	CY09	CY10
MHP	$3,333	$3,155	$3,311	$3,135
Large MHPs	$4,208	$4,254	$4,410	$4,288
Statewide	$4,485	$4,679	$4,841	$4,685

MEDI-CAL APPROVED CLAIMS HISTORY

The table below provides trend line information from the MHP's Medi-Cal eligibility and approved claims files from the last five fiscal years. The dollar figures are not adjusted for inflation.

Figure 12. MHP Medi-Cal Eligibility and Claims Trend Line Analysis

Fiscal Year	Average Number of Eligibles per Month	Number of Beneficiaries Served per Year	Penetration Rate		Total Approved Claims	Approved Claims per Beneficiary Served per Year	
			%	Rank		$	Rank
FY10-11	416,808	29,744	7.14%	27	$94,807,439	$3,187	43
FY09-10	424,038	30,809	7.27%	30	$95,228,053	$3,091	43
FY08-09	395,179	31,855	8.06%	28	$103,583,170	$3,252	38
FY07-08	373,433	31,422	8.41%	25	$95,486,775	$3,039	43
FY06-07	363,383	30,756	8.46%	24	$110,915,237	$3,606	33

MEDI-CAL DENIED CLAIMS HISTORY

Denied claims information appears in Figure 13. These are denials in Medi-Cal claims processing, not the result of disallowances or chart audits, and the rates do not reflect claims that may have been resubmitted and approved. Denial rate rank 1 is the highest percentage of denied claims; rank 56 is the lowest percentage of denied claims.

Figure 13. Medi-Cal Denied Claims Information

Fiscal Year	MHP Denied Claims Amount	MHP Denial Rate	MHP Denial Rate Rank	Statewide Median	Statewide Range
FY09-10	N/A	N/A	N/A	N/A	N/A
FY08-09	$1,347,082	1.36%	50	3.86%	0.41% - 29.87%
FY07-08	$1,394,451	2.06%	43	4.91%	0.23% - 25.89%
FY06-07	$1,290,508	1.30%	47	3.55%	0.23% - 18.18%
FY05-06	$1,296,533	1.26%	41	3.02%	0.57% - 22.69%

Review of Medi-Cal approved claims data, displayed in Figures 5 through 13 in Section III-C above, reflect the following issues that relate to quality and access to services:

- Decreases in the number of beneficiaries served and total Medi-Cal claims were observed for CY2010 compared to the prior year. For San Diego, CY10 approved claims data presented in this report is $94,223,184 with 30,051 beneficiaries served. For comparative purposes, during CY09 San Diego's approved claims totaled $105,172,737 and the number of beneficiaries served was 31,764. Overall, CY10 claims are approximately 11 percent lower than CY09 claims.
- The overall penetration rate remains above the comparative averages, but has declined from 8.4% in CY07 to 7.33% in CY10, in line with the statewide trend and that of other large MHPs. The MHP attributes this trend in part to their efforts to transfer care to primary health providers when appropriate.
- The average annual approved claims per beneficiary served for CY10 of $3,135 remains below the statewide mean and median (ranking 45th) and has decreased slightly from the prior year's rate of $3,311. This rate may be impacted to some degree by a lag in claims processing by the State and by the MHP's move to a short term treatment model beginning in 2010. This is also reflected by a decrease in the percentage of beneficiaries receiving more than 15 services from 36.35% in CY09 to 30.98% in CY10 and substantially below the statewide average of 40.42% as shown in the Retention Rates graph in Appendix D.
- Due to delayed implementation of key business rules for SD/MC Phase II system by the State the MHP claims submissions have also been delayed. Therefore, denied claims analyses for FY09-10 and FY10-11 is not currently available.

HIGH-COST BENEFICIARIES

As part of an analysis of service utilization, CAEQRO compiled claims data to identify the number and percentage of beneficiaries within each MHP and the state for whom a disproportionately high dollar amount of services were claimed and approved. A stable pattern over the last three calendar years of data reviewed shows that statewide, roughly 2% of the beneficiaries served accounted for one-quarter of the Medi-Cal expenditures. The percentage of beneficiaries meeting the high cost definition has increased in each of the four years analyzed. For purposes of this analysis, CAEQRO defined "high cost beneficiaries" as those whose services met or exceeded $30,000 in the calendar year examined—this figure represents roughly three standard deviations from the average cost per beneficiary statewide.

Figure 14. High-Cost Beneficiaries (greater than $30,000 per beneficiary)						
	Beneficiaries Served			Approved Claims		
	# HCB	# Served	%	Average per HCB	Total Claims for HCB	% of total claims
Statewide CY10	10,271	438,230	2.34%	$50,349	$517,136,571	25.19%
MHP CY10	443	30,051	1.47%	$44,762	$19,829,416	21.05%
MHP CY09	465	31,764	1.46%	$43,267	$20,119,023	19.13%
MHP CY08	398	31,844	1.25%	$44,309	$17,634,794	17.55%
MHP CY07	498	30,934	1.61%	$44,840	$22,330,473	21.66%

CAEQRO also analyzed claims data for beneficiaries receiving $20,000 to $30,000 in services per year. Statewide, this population also represents a small percentage of beneficiaries for which a disproportionately high amount of Medi-Cal dollars is claimed. Statewide in CY10, 37.11% of the approved Medi-Cal claims funded 4.64% of the beneficiaries served when this second tier of high cost beneficiaries is included. For the MHP, 34.61% of the approved Medi-Cal claims funded 3.19% of the beneficiaries served. This information is also depicted in pie charts in Attachment D.

- The MHP has consistently been below the statewide average for beneficiaries utilizing more that $30,000 in services. This trend continued in CY2010 with rate of 1.47% compared to the statewide rate of 2.34%.
- The 3.19% rate of MHP beneficiaries utilizing more than $20,000 in services for CY2010 is also below the statewide average of 4.21%.

❖PERFORMANCE MEASUREMENT❖

Each year CAEQRO is required to work in consultation with DMH to identify a performance measurement (PM) which will apply to all MHPs – submitted to DMH within the annual report due on August 31, 2012. These measures will be identified in consultation with DMH for inclusion in this year's annual report.

❖CONSUMER AND FAMILY MEMBER FOCUS GROUPS❖

FOCUS GROUP(S) SPECIFIC TO THE MHP

CAEQRO conducted three 90-minute focus groups with consumers and family members during the site review of the MHP. As part of the pre-site planning process, CAEQRO requested focus groups as follows:

1. A diverse group of adults who receive services from an MHP contractor specializing in treatment for the deaf community.

2. A diverse group of parents/caregivers of minor children with preference for those who initiated services within the past year.

3. A group of Latino beneficiaries, primarily Spanish-speaking, with preference for those who have initiated services within the past year.

The focus group questions were specific to the MHP reviewed and emphasized the availability of timely access to services, recovery, peer support, cultural competence, improved outcomes, and consumer and family member involvement. CAEQRO provided gift certificates to thank the consumers and family members for their participation.

CONSUMER/FAMILY MEMBER FOCUS GROUP 1

This focus group was held at Deaf Community Services. Six men participated. The participants' length of time in services ranged from three days to six years. Although a couple of the men grew up locally, the majority moved to San Diego specifically to receive services from this agency. Participants described a pattern of relocating to several different parts of the country to access the meager substance abuse and mental health services geared for deaf consumers that exist nationally. The majority of the group was receiving both substance abuse services and mental health services.

Entry into services was described as easy—it appeared that, at least for this cohort, referrals are often made in advance of the relocation and services are available upon arrival. One of the more recently arrived participants had already moved into a deaf sober living situation and had a benefits appointment scheduled. Many of the participants described their providers as available weekly or as needed, although same day appointments were difficult to obtain. Multiple methods of communication were described, including text messaging and using video interpreter services via an online service when accessing emergency room services.

Communication barriers also exist. The group expressed mild frustration with revolving volunteer front office staff who may be only marginally proficient in American Sign Language (ASL). Paid provider staff within the program itself were described as fluent in ASL, however, the program has no on-site psychiatrist. Psychiatry services are utilized through an interpreter, which was also described as frustrating, since interpretation was not felt to adequately bridge the cultural divide between the deaf and hearing worlds. Group members felt that signs of distress or suicidality in a deaf person could easily be overlooked by a hearing clinician.

Participants reported other limitations with interpretation—for example, when an interpreter is present on an inpatient unit, he/she is only there for a small portion of the time. When the interpreter leaves it is very difficult to participate in meetings for hearing consumers. Similarly, these participants found that they were not able to benefit from Clubhouses or Wellness Centers, since they were not able to form the kinds of friendships with hearing consumers that are the cornerstone of such programs.

Even within Deaf Community Services the communication was described as only fair. The participants pointed out that the agency made no use of communication methods such as bulletin boards or newsletters. As a result, when important program changes occurred (like the on-site food bank shutting down), clear and timely information was not available.

Participants described an inability to access a comprehensive array of services and felt that they were limited to utilizing the offerings of Deaf Community Services, whether or not they were tailored to their presenting problems. They described little ability to provide input on program development, policy and procedure, and reported a willingness to participate in such committees. Overall the reality was expressed that this program of necessity had to fill all the needs of its consumers, and that this resulted in a sense of isolation from the hearing portions of the MHP.

Recommendations from this group included:

- Increase outreach and education to the deaf community.
- Provide transportation to make services available to those living in outlying communities.
- Provide after hours and weekend services.
- Expand the array of services offered to include eating disorder treatment, older adult services and independent living skills classes, such as those targeting nutrition and exercise.
- Hire a psychiatrist who understands deaf culture.

Figure 15. Consumer/Family Member Focus Group 1

Number/Type of Participants	
Consumer Only	2
Consumer and Family Member	4
Family Member of Adult	
Family Member of Child	3
Family Member of Adult & Child	1
Total Participants	6

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	
Adult (approx 25-59)	5
Older Adult (approx 60 and older)	1

Preferred Languages	
American Sign Language	6

Estimated Race/Ethnicity	
African American	3
Caucasian	2
Mixed Race	1

Gender	
Male	6
Female	0

Interpreter used for focus group 1: ☐ No ☒ Yes Language: American Sign Language

CONSUMER/FAMILY MEMBER FOCUS GROUP 2

This Focus Group for parents and caregivers was scheduled to be held at Social Advocates for Youth (SAY) San Diego. Only one participant attended, so no formal focus group was held, although this participant was interviewed with the use of an interpreter. To preserve the confidentiality of this participant, her individual responses are not recorded here, but are used where appropriate in related areas of the report.

Figure 16. Consumer/Family Member Focus Group 2

Number/Type of Participants	
Consumer Only	
Consumer and Family Member	
Family Member of Adult	
Family Member of Child	1
Family Member of Adult & Child	
Total Participants	1

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	
Adult (approx 25-59)	1
Older Adult (approx 60 and older)	

Preferred Languages	
Spanish	1

Estimated Race/Ethnicity	
Latina	1

Gender	
Male	
Female	1

Interpreter used for focus group 2: ☐ No ☒ Yes Language: Spanish

CONSUMER/FAMILY MEMBER FOCUS GROUP 3

The focus group was held at the East County Mental Health Clinic (ECMHC). Some of the eleven participants assisted in translating, as there was no Spanish/English translator provided for the focus group. Participants had been involved with MHP services from between six months to longer than 27 years. Most of those who had initiated services within the past couple of years reported being seen for an initial service within one to two weeks of requesting services. Some had learned about outpatient services while receiving inpatient services, and one person described outreach workers visiting her while hospitalized.

The participants unanimously agreed they felt a sense of hope for personal recovery and were overwhelmingly positive about the services received. One person stated "help is just a phone call away," and another stated she chooses to come to the ECMHC even though there is a clinic closer to her home because the staff at this site are so helpful to her. All participants agreed that they feel their culture is respected by staff and that they knew how to access services after hours and/or during a crisis.

Many of the participants had seen some of the MHP stigma reduction media campaign, yet only two had heard of the clubhouses. A variety of printed materials, including bilingual fotonovelas, was available in the clinic waiting room, and some participants reported finding the material to be helpful both personally and for educating their families. One person stated he

had not seen the materials before the focus group but found them helpful to read during the group.

While many group members reported completing satisfaction surveys in the past, none had participated in decision-making committees or were aware of opportunities to participate in mental health service delivery system planning or program implementation. Many expressed interest in this level of involvement in the future.

Figure 17 Consumer/Family Member Focus Group 3

Number/Type of Participants	
Consumer Only	7
Consumer and Family Member	3
Family Member of Adult	1
Family Member of Child	
Family Member of Adult & Child	
Total Participants	11

Estimated Ages of Participants	
Under 18	
Young Adult (approx 18-24)	1
Adult (approx 25-59)	7
Older Adult (approx 60 and older)	3

Preferred Languages	
English	5
Spanish	6

Estimated Race/Ethnicity	
Latino/Hispanic	9
Latino/Caucasian	1
Latino/Asian	1

Gender	
Male	5
Female	6

Interpreter used for focus group 3: ☐ No ☒ Yes: Spanish (group members translated – no translator was provided.)

❖PERFORMANCE IMPROVEMENT PROJECT VALIDATION❖

CLINICAL PIP

The MHP presented its study question for the clinical PIP as follows:

> "Will implementing activities such as identification of predictors of high service utilization and the development of appropriate early childhood interventions lead to enhanced quality, effectiveness, and efficiency of service delivery to children, ages 0-5, receiving EPSDT funded mental health services?"

Year PIP began: 2008

Status of PIP:

- ☐ Active and ongoing
- ☒ Completed - rated as active during the review period
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

This was the final year of this statewide EPSDT PIP; please refer to reports from prior years for additional background information. This PIP is no longer a statewide requirement and the MHP has brought this project to a close during the review year, although the interventions initiated and the evaluation thereof will be ongoing.

In analyzing the high cost data, the MHP noted a confluence of factors contributing to a high cost profile: Child Welfare Services (CWS) involvement and clinically significant behavioral problems at an early age combined with an array of biological and psychosocial risk factors, including trauma. To meet the needs of this identified cohort the MHP developed the KidSTART (Screening, Triage, Assessment, Referral and Treatment) Center in partnership with HHSA using First Five Commission tobacco tax funds to provide services to CWS foster children 0-5 years, including EPSDT mental health services. The KidSTART Center EPSDT South Clinic opened in July 2010 in Chula Vista and now provides systematic developmental screening for all children entering foster care through the Developmental Screening and Evaluation Program (DSEP). KidSTART has increased the involvement of caregivers in all aspects of children's' care, from systematically including their input during screenings and assessments, to inclusion in treatment services. For children with mental health needs, a variety of evidence based treatments are available, including cognitive focused treatment, trauma informed treatment, psychotherapy, and Parent Child Interaction Therapy. This PIP has resulted in greatly increased ability to provide appropriate services for children aged 0-5, and has also increased access to FSP and TBS programs for this age cohort.

At follow up measurement, 67% of children demonstrated improvement in behavioral and social emotional problems, 100% of children had been screened for developmental and social emotional delays (n = 1072) and 100% of children had caregiver participation in their treatment. Since KidSTART is a new program developed during this PIP, ongoing measurement and program refinements are planned.

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either "met," "partial," "not met," or "not applicable." Relevant details of these issues and recommendations are included within the comments of the PIP validation tool.

Thirteen of the 44 criteria are identified as "key elements" indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 18. Clinical PIP Validation Review—Summary of Key Elements

Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
2	The study question identifies the problem targeted for improvement	X		
3	The study question is answerable/demonstrable	X		
4	The indicators are clearly defined, objective, and measurable	X		
5	The indicators are designed to answer the study question		X	
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
7	The indicators each have accessible data that can be collected	X		
8	The study population is accurately and completely defined	X		
9	The data methodology outlines a defined and systematic process	X		
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes	X		

Figure 18. Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
11	The analyses and study results are conducted according to the data analyses plan in the study design	X		
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion	X		
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement	X		
Totals for 13 key criteria		**10**	**3**	**0**

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIPs as submitted by the MHP are included in an attachment to this report.

NON-CLINICAL PIP

The MHP presented its study question for the non-clinical PIP as follows:

> "Is a comprehensive, multi-media education campaign an effective method to improve public awareness and knowledge about mental illness and an effective vehicle to help decrease stigma and discrimination about persons with mental illness?"

Year PIP began: 2010

Status of PIP:

- ☐ Active and ongoing
- ☒ Completed - rated as active during the review period
- ☐ Inactive, developed in a prior year
- ☐ Concept only, not yet active
- ☐ No PIP submitted

The MHP (in conjunction with academic and industry partners) used PEI funds to launch a comprehensive anti-stigma and suicide prevention multi media campaign to reduce barriers to seeking mental health treatment by the San Diego population as a whole and by targeted underrepresented demographic groups (racial/ethnic minorities, transitional aged youth and older adults) in specific. Print ads, radio and television spots, and a website (www.Up2SD.org) were utilized in this campaign. A robust stakeholder process was utilized throughout the initial

creation and subsequent evolution of the media campaign, with focus groups providing input on campaign wording, visuals, scenarios and actors. Two waves of Random Digit Dialed telephonic surveys of a representative sample of approximately 600 San Diegans were utilized to gather demographic and treatment history information and to assess the impact of the media campaign (Wave I baseline interviews collected April 2010, Wave II follow up interviews collected after six months of media campaign conducted March 2011, Wave III interviews are scheduled for March 2012.)

Wave II results showed improvement on measures of interpersonal stigma, attitudes about mental illness and willingness to seek help. More individuals reported being in treatment than had done so in the baseline interview. Call volume to the Access Center was measured and was found to increase significantly during the interval following the airing of anti-stigma television spots. Using data from Wave II, the MHP extrapolates that over 50% of San Diegans were exposed to this intensive media campaign. The focus of the ad campaign continues to be refined based on stakeholder and survey feedback. Future ads are planned that introduce an empowerment theme to the campaign and feature mental health consumers "talking back" to stigmatizing statements.

CAEQRO applied the PIP validation tool, which follows in Attachment E, to all PIPs – rating each of the 44 individual elements as either "met," "partial," "not met," or "not applicable." Relevant details of these issues and recommendations are included within the comments of the PIP validation tool.

Thirteen of the 44 criteria are identified as "key elements" indicating areas that are critical to the success of a PIP. These items are noted in grey shading in the PIP Validation Tool included as Attachment E. The results for these thirteen items are listed in the table below.

Figure 19. Non-Clinical PIP Validation Review—Summary of Key Elements

Step	Key Elements	Present	Partial	Not Met
1	The study topic has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
2	The study question identifies the problem targeted for improvement	X		
3	The study question is answerable/demonstrable	X		
4	The indicators are clearly defined, objective, and measurable	X		
5	The indicators are designed to answer the study question	X		

Figure 19. Non-Clinical PIP Validation Review—Summary of Key Elements				
Step	Key Elements	Present	Partial	Not Met
6	The indicators are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X		
7	The indicators each have accessible data that can be collected	X		
8	The study population is accurately and completely defined	X		
9	The data methodology outlines a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X		
10	The interventions for improvement are related to causes/barriers identified through data analyses and QI processes	X		
11	The analyses and study results are conducted according to the data analyses plan in the study design	X		
12	The analyses and study results are presented in an accurate, clear, and easily understood fashion	X		
13	The study results include the interpretation of findings and the extent to which the study demonstrates true improvement	X		
Totals for 13 key criteria		**13**	**0**	**0**

CAEQRO offered further technical assistance as needed as the MHP continues to develop, implement, and improve this or other PIPs. The PIPs as submitted by the MHP are included in an attachment to this report.

❖INFORMATION SYSTEMS REVIEW❖

Knowledge of the capabilities of an MHP's information system is essential to evaluate the MHP's capacity to manage the health care of its beneficiaries. CAEQRO used the written response to standard questions posed in the California-specific ISCA Version 7.2, additional documents submitted by the MHP, and information gathered in interviews to complete the information systems evaluation.

CURRENT OPERATIONS

- The MHP is continuing to implement the Anasazi Client Data, Assessment and Treatment Plan, and Managed Care Organization software from Anasazi Software Inc.
- Both the billing and clinical electronic health record (EHR) components are utilized by MHP staff and all outpatient organizational providers.
- Hardware and software management for Anasazi is provided via contract with Hewlett Packard, Inc (HP).
- Inpatient and network provider authorization and reporting occur through a contract with Optum Health.
- Optum Health hired one technology staff person and one person left; there are no unfilled positions. At present there are about 17 FTE positions that provide support to San Diego Behavioral Health Services.
- The MHP hired one technology staff person and 1.5FTE positions were eliminated; there are no unfilled positions. At present the MHP has 3 FTE positions allocated.

MAJOR CHANGES SINCE LAST YEAR

- The contract to support San Diego County Health and Human Services Agency computer operations, hardware, network installation, and support changed from Northrop Grumman to HP.
- The Anasazi treatment plan and progress notes components have become operational.

PRIORITIES FOR THE COMING YEAR

- Completion of EHR implementation (E-prescribing, treatment plans, and progress notes).
- Completion of HIPAA 5010 testing and claiming implementation.
- Resolution of system latency issues.
- Planning for disaster recovery system.
- Development of archive for legacy systems.
- Completion of bringing CSI reporting up to date.

OTHER SIGNIFICANT ISSUES

- Anasazi users report frequent problems with screen "freezes" and slow performance.
- Users have expressed dissatisfaction with complexity and work flow requirements for completion of electronic assessments and treatment plans.
- Technical limitations resulting from the Anasazi hardware configuration and software selection for the database and client sessions has resulted in difficulty in running some processes, such as CSI, and inability to utilize some Anasazi components.
- The time lag of three weeks or more in establishing an account and completing initial training for new IS users is excessive.
- Contract providers continue to raise concerns about the lack of inter-operability between their in-house systems and Anasazi despite frequent planning meetings.

The table below lists the primary systems and applications the MHP uses to conduct business and manage operations. These systems support data collection and storage, provide electronic health record (EHR) functionality, produce Short-Doyle/Medi-Cal (SD/MC) and other third party claims, track revenue, perform managed care activities, and provide information for analyses and reporting.

Figure 20. Current Systems/Applications				
System/Application	Function	Vendor/Supplier	Years Used	Operated By
Anasazi	Practice Management, EHR	Anasazi	3	MHP IS, Agency IS, ASO - Optum IS
ChartOne	Psychiatric Hospital EHR	Anacomp	6	Vendor IS
Inpatient	Medications, Meds Locker, Vital Signs, Alerts	Cerner	2	Vendor IS
Pharmacy	Meds Inventory	Etreby	2	Vendor IS
InSyst (Legacy)	Billing, Reporting, Practice Management	The Echo Group	14	ASO – Optum IS
e-Cura (Legacy)	Managed Care	InfoMC	13	ASO- Optum IS

PLANS FOR INFORMATION SYSTEMS CHANGE

The MHP is continuing implementation of the Anasazi clinical components and has no plans for information system change other than to upgrade to newer versions of the EHR and reporting modules as they become available.

ELECTRONIC HEALTH RECORD STATUS

See the table below for a listing of EHR functionality currently in widespread use at the MHP.

Figure 21. Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Assessments	Anasazi	X			
Document imaging	ChartOne Available to SD County Psychiatric Hospital staff		X		
Electronic signature-client				X	
Electronic signature-provider	Anasazi EHR, ChartOne Available to SD County Psychiatric Hospital staff	X			
Laboratory results				X	

Figure 21. Current EHR Functionality					
Function	System/Application	Rating			
		Present	Partially Present	Not Present	Not Rated
Outcomes				X	
Prescriptions	Cerner and Etreby Available to SD County Psychiatric Hospital staff		X		
Progress notes	Anasazi		X		
Treatment plans	Anasazi		X		

Progress and issues associated with implementing an electronic health record over the past year are discussed below:

- Electronic treatment plans and progress notes are being implemented at provider sites for clinical staff and physicians as training is completed.
- Implementation of outpatient E-prescribing via Doctor's Homepage in Anasazi is scheduled to begin in April 2012.

❖SITE REVIEW PROCESS BARRIERS❖

The following conditions significantly affected CAEQRO's ability to prepare for and/or conduct a comprehensive review:

- The Contract Providers Administrators Group Interview and the Parent/Caregiver Focus Group were each attended by only one person, which impacted the ability to gather information from these stakeholder groups.
- No interpreter was provided for the bilingual Hispanic Focus Group.

❖CONCLUSIONS❖

During the FY11-12 annual review, CAEQRO found strengths in the MHP's programs, practices, or information systems that have a significant impact on the overall delivery system and its supporting structure. In those same areas, CAEQRO also noted opportunities for quality improvement. The findings presented below relate to the operation of an effective managed care organization, reflecting the MHP's processes for ensuring access and timeliness of services and improving the quality of care.

STRENGTHS

1. The MHP continues with a strong quality improvement culture with a focus on performance improvement.
   [Quality, Outcomes]

2. The MHP has implemented a comprehensive anti-stigma and suicide prevention campaign to improve the general social environment for persons living with mental illness and to reduce treatment barriers in particular for identified vulnerable populations.
   [Access]

3. The MHP continues to utilize dashboards and other reports for data driven decision making.
   [Quality, Outcomes]

4. The MHP provides consistent vision, leadership and expertise in the domain of behavioral health/primary care integration.
   [Access, Outcomes]

5. The MHP continues with strongly collaborative relationships with criminal justice and law enforcement partners as well as alcohol and drug services and primary care.
   [Quality, Other: Collaboration]

OPPORTUNITIES FOR IMPROVEMENT

1. Accurate and timely reporting of hospital discharge data has not been implemented.
   [Timeliness, Information Systems]

2. Missed appointment data is incompletely studied which negatively impacts the ability to determine system-wide capacity and timeliness to services.
   [Access, Timeliness]

3. Ongoing issues with information system performance raise concerns about user engagement in the EHR implementation.
   [Information Systems]

4 The MHP is lacking business plan and strategy to capture client's signatures on electronic forms.
   [Information Systems]

5 Consumer and family member employees lack clear and consistent role definitions and expectations. The MHP provides monthly training and support meetings for youth and family advocates, but the opportunity for staff to participate in these meetings varies widely between contract agencies.
   [Quality, Other: Wellness and Recovery]

6 Little progress has been made in developing an IS disaster recovery system or for creating an accessible archive of legacy systems data despite the fact that they were listed as MHP priorities last year.
   [Information Systems]

7 While extensive outcome data exists, it is unevenly disseminated.
   [Outcomes, Other: Communication]

8. The MHP utilizes multiple websites for consumer and stakeholder communication which are not linked.
   [Quality, Other: Communication]

RECOMMENDATIONS

The following recommendations are in response to the opportunities for improvement identified during the review process, identified as an issue of access, timeliness, outcomes, quality, information systems, or others that apply:

1. Develop and implement a strategy for obtaining accurate and timely hospital discharge data and utilize that data to provide and monitor timely post hospital follow up to consumers leaving psychiatric inpatient units.
   [Timeliness, Information Systems]

2. Expand the study of missed appointments system wide to better measure service capacity and timeliness to service levels.
   [Access, Timeliness]

3. Develop a plan for the resolution of IS performance issues by the end of the year.
   [Information Systems]

4. Implement Anasazi signature pads to electronically capture client's signature on forms.
   [Information Systems]

5. Establish clear guidelines and expectations of job duties and training opportunities for peer, youth, and family partner positions. This will benefit those employed in positions for persons with lived experience as well as those in traditional professional positions.
   [Quality, Other: Wellness and Recovery]

6. Develop a work plan and timeline for an IS disaster recovery plan and accessible archive for the legacy systems.
   [Information Systems]

7. Using available technology, develop and utilize a system for reporting relevant functional and clinical outcomes to direct service staff as well as consumers and family members.
   [Outcomes, Other: Communication]

8. Provide internet links between the Network of Care, Health and Human Service Agency and the Up2SD websites to facilitate communication and linkage to services.
   [Information Systems, Other: Communication]

❖ATTACHMENTS❖

Attachment A: Review Agenda

Attachment B: Review Participants

Attachment C: Approved Claims Source Data

Attachment D: Data Provided to the MHP

Attachment E: CAEQRO PIP Validation Tools

Attachment F: MHP PIP Summaries Submitted

A. Attachment—Review Agenda

<table>
<tr><th>Time</th><th colspan="3">Wednesday, February 22 – Day 1</th></tr>
<tr><td>9:00-12:00</td><td colspan="3"><u>Performance Management</u>

Access, Timeliness, Outcomes, and Quality</td></tr>
<tr><td></td><td colspan="2">● Introduction of participants
● Overview of review intent
● Significant MHP changes in past year
● Last Year's CAEQRO Recommendations</td><td>● Performance improvement measurements utilized to assess access, timeliness, outcomes, and quality
● Examples of MHP reports used for to manage performance and decisions
● CAEQRO approved claims data</td></tr>
<tr><td></td><td colspan="3">Participants – Those in authority to identify relevant issues, conduct performance improvement activities, and implement solutions –including but not limited to:
○ MHP Director, senior management team, and other managers/senior staff in: Fiscal, program, IS, medical, QI, research, patients' rights advocate
○ Involved consumer and family member representatives</td></tr>
<tr><td>12:00-1:00</td><td colspan="3">APS Staff – Working Lunch</td></tr>
<tr><td>See specified times</td><td><u>Travel 1-1:30</u>

<u>1:30-3:00</u>

<u>Consumer/Family Member Focus Group – Deaf Community Services</u>

8-10 participants as specified in the notification letter</td><td><u>1:00 – 2:30</u>

<u>Program Managers Group Interview</u>

10-12 program managers representing county and contractor programs serving a variety of sites and age groups</td><td><u>1:00 – 2:30</u>

<u>IS Manager/Key IS Staff Group Interview</u>

• Review and discuss ISCA
• FY 10-11 CAEQRO IT recommendations</td></tr>
<tr><td>See specified times</td><td><u>Travel 3-3:30</u>

<u>3:30-5:00</u>

<u>Consumer/Family Member Focus Group – SAY SAN DIEGO</u>

8-10 participants (adult caregivers of children receiving services) as specified in the notification letter</td><td><u>2:45-4:15</u>

<u>Clinical Line Staff Group Interview</u>

7-9 clinical line staff group of contract provider programs representing a geographical areas and age groups</td><td><u>2:45 – 4:15</u>

<u>IS Implementation Work Group Interview</u>

• Users and planners
• Clinical & non-clinical staff MHP and provider staff - CORE Role</td></tr>
</table>

Time	Thursday, February 23 – Day 2		
9:00-10:15	**HOPE CONNECTIONS – Peer/Family Employee Group Interview (Adults)**	**Site Visit to Optum Health** Group Interview with David White and network provider authorization unit	**Contract Provider Administrators Group Interview** Group Interview with clinical & business administrators (CEO, COO, CFO, Clinic Directors) from 6-8 identified contract providers
10:30-12:00	**Family Member Employee Group Interview – Parent Partners (Kids)** 6-8 Children's Liaisons and other family members employed by the MHP or contractors	**Site Visit to The Corner Clubhouse**	**Disparities in Service Access, Retention, Quality, or Outcomes** • Review of MHP data to examine penetration rates & utilization patterns by age, ethnicity, or gender • Review of Cultural Competency strategies to improve access/ engagement & improve health equity • Review of activities to address overall capacity • Evidence based or best practices for diverse or high risk populations
12:00-1:00	**APS Staff – Working Lunch**		
1:30-3:30	**Travel 1-1:30** **Consumer/Family Member Focus Group –Latino Adult Consumers** 8-10 participants as specified in the notification letter *East County Mental Health Clinic (ECMHC)*	**Collaborative/ Community Based Services** Examples of collaborative relationships with community providers and other agencies: • With Law Enforcement • With Alcohol and Drug Services • With Child Welfare Services	**Administrative Analyst Interview** 6-8 Administrative Analysts—county employees • Behavioral Health Revenue • Contract & Data Coordination • Contract Fiscal Invoice Review • Contract Fiscal Provider • MH Performance Outcomes • Strategic Planning • COTAR • Health Agency Management Analyst
3:30-5:00	**ECMHC Program Manger/Staff Group Interview** • Discussion on Walk-In Clinic • Wellness Center • Telepsychiatry		**Fiscal/Billing/Finance Group Interview – SD/MC Claims Processing** • Short-Doyle Phase 2 claim process • Medicare/Medi-Cal claim submissions for Contract Providers • Void & Replace claim transactions • New policies & procedures since last review

<table>
<tr><th>Time</th><th colspan="2">Friday, February 24 – Day 3</th></tr>
<tr><td>9:00-10:30</td><td><u>Performance Improvement Projects</u>

Discussion includes topic and study question selection, baseline data, barrier analysis, intervention selection, methodology, results, and plans

Participants should be those involved in the development and implementation of PIPs, including, but not necessarily limited to:
• PIP committee
• MHP Director and other senior managers</td><td><u>Douglas Young Clinic Site Visit</u>

Hands on Session demonstrating implementation of Client Plan, Progress Notes and e-Prescribing</td></tr>
<tr><td>10:45-12:00</td><td><u>Advocacy Interview</u>

6-8 Advocacy Contractors

• Review of role of advocates and improvement activities
• Stakeholder involvement and input
• Consumer Satisfaction</td><td><u>Outcomes/Timeliness</u>

MHP examples of data used to measure timeliness, functional outcomes and satisfaction</td></tr>
<tr><td>12:00-1:00</td><td colspan="2">APS Staff – Working Lunch</td></tr>
<tr><td>1:00-2:30</td><td colspan="2"><u>Primary Care Integration</u>

Examples of collaborative relationships and service integration with community primary care providers</td></tr>
<tr><td>2:30-3:00</td><td colspan="2">APS Staff Meeting</td></tr>
<tr><td>3:00-3:30</td><td colspan="2"><u>Final Questions Session</u>

MHP Director, QI Director, Senior leadership, and APS staff only

• Clarification discussion on any outstanding review elements
• MHP opportunity to provide additional evidence of performance
• CAEQRO Next steps after the review</td></tr>
</table>

B. Attachment—Review Participants

CAEQRO Reviewers

Dawn Kaiser, Lead Reviewer
Samantha Fusselman, Site Reviewer
Jerry Marks, Information Systems Reviewer
Bill Ullom, Site Reviewer
Debbie Strong Consumer/Family Member Consultant

Additional CAEQRO staff members were involved in the review process, assessments, and recommendations. They provided significant contributions to the overall review by participating in both the pre-site and the post-site meetings and, ultimately, in the recommendations within this report.

Sites of MHP Review

CAEQRO staff visited the locations of the following county-operated and contract providers:

County provider sites

San Diego County Administrative Offices
3255 Camino Del Rio South, San Diego, CA

San Diego County Psychiatric Hospital
3853 Rosecrans Street, San Diego, CA 92110

Contract provider organizations

The Corner Clubhouse
2864 University Avenue, San Diego, CA 92104

Deaf Community Services
3930 4th Avenue, Suite 300, San Diego, CA 92103

Douglas Young Clinic
10717 Camino Ruiz Ste. 207, San Diego, CA 92126

East County Mental Health Clinic
1000 Broadway, Suite 210, El Cajon, CA 92021

Health Services Complex
3851 Rosecrans, San Diego, CA 92110

Optum Health
3111 Camino del Rio North, Suite 500, San Diego, CA 92108

SAY San Diego
4275 El Cajon Boulevard, Suite 101, San Diego, CA 92105

PARTICIPANTS REPRESENTING THE MHP

Abel Pena, Licensed Mental Health Clinician
Alfie Gonzaga, Principal Administrative Analyst
Alfredo Aguirre, Mental Health Director
Ali Freedman, Contractor, Fred Finch Youth Center Program
Alma Correa, Program Evaluator/Coordinator, University of California, San Diego
Alma Porley, Mental Health Resource Specialist,
Amelia Gauingab, Principal Administrative Analyst
Ami Rosechlein, Program Manager, University of California, San Diego
Amy Chadwick, Project Coordinator, Child Adolescent Services Researcher
Ana Briones-Esperioza, Senior Manager of Business Analysis, Optum Health
Andrea Magee, Peer Specialist
Andrew Sarkin, Manager, University of California, San Diego
Angie DeVoss, Administrative Service Manager
Anne Fitzgerald, Program Manager
Anselma Danque, Associate Accountant
Brandi Marcoe, Program Manager, NAMI Helpline
Bret Vedder, Administrative Analyst
Candace Milow, Director, Quality Improvement
Carly Graber, Communications Coordinator, Family and Youth Roundtable
Carol Neidenberg, Manager, Consumer Center
Catherine Balinbin, Mental Health Case Management Clinician
Cecilia Redondo, Chief, PAS
Celeste Hunter, Family Partner, UCSD Child and Adolescent Research Center
Chona Penalba, Principal Accountant, Fiscal
Dan Maccia, Regional Coordinator/Program Director, Community Research Foundation
Debbie Melcarne, Program Coordinator
Debra McFarland, Family/Peer Specialist
Devin Eshelman, Peer Specialist
Diana Cobb
Diana Venegas, Parent Partner, Community Services
Donna Ewing Marto, CEO-FYRT, CMHS Liaison
Donna Peterson, Administrative Analyst

Dora Catalano, Peer Liaison, Recovery Innovations
Edd Urbano, Administrative Analyst
Edith Mohler, Administrative Analyst
Emily Trask, Senior Mental Health Researcher, University of California, San Diego
Gary Hubbard, Regional Director of Operations, TeleCare Corporations
Gina Brown, Administrative Analyst
Hal May, Family Specialist
Ian Rosengarten, Quality Improvement Specialist
Jeff Rows, Supervising Psychologist
Jennifer Whelan, Program Manager, Douglas Young Clinic
Jennifer Schaffer, Director, Behavioral Health Services
Jennifer Leich, Project Manager, University of California, San Diego
Jennifer Mallory, Administrative Analyst
Jerry Wilkins, Administrative Analyst
Jill Johnson, Administrative Analyst
Jim Lardy, Financial Officer
Joyce Thompson, Utilization Manager, Optum Health
Judi Holder, Recovery Service Administrator, Recovery Innovations
Junida Bersabe, Principal Administrative Assistant
Karen Hayman, Support Service Coordinator, Recovery Innovations
Karen Ventimiglia, Coordinator
Karen Hempstead, Regional Coordinator/Program Director, Community Research Foundation
Karyn Donado, Program Manager, Kinesis North Clinic
Kathy Anderson, Manager, Performance Outcomes
Katie Astor, Assistant Deputy Director
Kim May, Mental Health Advocate, Consumer Center
Kristina Maxwell, Administrative Analyst
Kya Fawley-King, Post Doctoral Fellow, Child Adolescent Services Research Center
Laura Andrews, Senior Outreach Services Coordinator, Mental Health America of San Diego
Lauren Chin, Health Planning and Program Specialist
Lauretta Monise, Chief, Children and Adult Mental Health Services
Lavonne Lucas, Health and Human Services
Leah Straley, Supervisor, JFS Patient's Advocacy
Lidia Espinoza, Community Outreach Specialist, Palomar Family Council
Linda Richardson, Program Manager
Lita Carvalho, Support Partner Supervisor, Families Forward
Liz Miles, Administrative Analyst
Lorna Amarila, Administrative Analyst
Luvone Lucas, Health Services Representative
Magdalena Kountz, Family Support Partner, San Diego Youth Services
Mahvash Alami, Program Manager

Maria Lopez, Program Specialist
Maria Morgan, Program Director, Kick Start
Maria Palomo, Behavioral Health Program Supervisor, No County Life Line
Maria Valdez, Peer 2 Peer Supportline, Mental Health Services
Marissa Crane, Program Evaluation Specialist, University of California, San Diego
Marshall Lewis, Behavior Health Clinical Director
Mary Benson, Peer Liaison Team Leader, Recovery Innovations
Mary Daleo, FSP, Families Forward
Mary Joyce, Director of Quality and Provider Services, Optum Health
Meghan Maiya, Program Evaluations Specialists, University of California, San Diego
Melinda FurFuro, Program Manager, San Diego Youth Services
Melody Culhane, Program Supervisor, Kinesis North Clinic
Mercedes Webber, Peer Liaison, Recovery Innovations
Michalene Holtsley, Supervisor, Quality Improvement
Michele LaScala, Psychiatric Nurse
Michelle Walker, Transitional Aged Youth Lead Counselor, Douglas Young Clinic
Michelle Galvan, Director of Business Operations, Optum Health
Mike Phillips, Director, JFS Patients' Rights Advocate
Mylene Fitzgerald, Associate Accountant
Nilsa Rubenstein, System Administrator, Optum Health
Noelle Deane, Behavioral Health Clinical Supervisor, North County Lifeline
Ofelia Valdez-Najar, Administrative Analyst
Patricia Fulgencio, Family Support Partner, Harmonium
Piedad Garcia, Assistant Deputy Director
Rachel Wofford, Palomar Family Council, San Diego Youth Services
Rebecca Cruz, Youth Support Partner, Families Forward
Red Galura, Peer Specialist
Rick Heller, Community Health Program Representative, University of California, San Diego
Rosa Velasquez, Community Outreach Specialist, Palomar Family Council
Ruth Kenzelmann, Executive Director, Optum Health
Samantha Lea, Research Analyst
Sandy Gutierrez, Family Support Partner, Families Forward
Saya Eto-Barba, Administrative Analyst
Scott Elizondo, Program Manager, Kinesis North Clinic
Steve Jones, Program Manager, Quality Improvement
Steve Cooper, Director/Community Engagement, Family and Youth Roundtable
Steven Tally, Health Services Representative, University of California, San Diego
Sue McCay, FSP Supervisor, Families Forward
Susan Bower, Director-ADS
Susie Berman, Peer Specialist
Tabatha Lang, Program Coordinator
Tara Sharpell, Discharge Planner, Community Research Foundation

Tarsila Jaca, Administrative Analyst
Terry Villaera, Director of Clinical Operations, Optum Health
Theresa Vasquez, Administrative Analyst
Toroshinia Kennedy, Administrative Analyst
Trang Tran, Quality Improvement Supervisor
Virginia West, Program Coordinator
Wendy Maramba, Assistant Administrator
William Penfold, Senior IT Manager, Optum Health
Yael Koenig, Chief, Children's Mental Health Services

C. Attachment—Approved Claims Source Data

- **Source:** Data in Figures 5 through 14 and Appendix D are derived from four statewide source files:
  - Short-Doyle/Medi-Cal approved claims (SD/MC) from the Department of Mental Health (DMH)
  - Short-Doyle/Medi-Cal denied claims (SD/MC–D) from the Department of Mental Health
  - Inpatient Consolidation claims (IPC) from the Department of Health Care Services via DMH
  - Monthly MEDS Extract Files (MMEF) from the Department of Health Care Services via DMH

- **Selection Criteria:**
  - Medi-Cal beneficiaries for whom the MHP is the "County of Fiscal Responsibility" are included, even when the beneficiary was served by another MHP
  - Medi-Cal beneficiaries with aid codes eligible for SD/MC program funding are included

- **Process Date:** The date DMH processes files for CAEQRO. The files include claims for the service period indicated, calendar year (CY) or fiscal year (FY), processed through the preceding month. For example, the CY2008 file with a DMH process date of April 28, 2009 includes claims with service dates between January 1 and December 31, 2008 processed by DMH through March 2009.

  - CY2010 includes SD/MC and IPC approved claims with process date November 2011
  - CY2009 includes SD/MC and IPC approved claims with process date February 2011
  - CY2008 includes SD/MC and IPC approved claims with process date December 2009
  - CY2007 includes SD/MC and IPC approved claims with process date April 2009
  - CY2006 includes SD/MC and IPC approved claims with process date October 2007
  - CY2005 includes SD/MC and IPC approved claims with process date July 2006
  - FY10-11 includes SD/MC and IPC approved claims with process date November 2011
  - FY09-10 includes SD/MC and IPC approved claims with process date February 2011
  - FY08-09 includes SD/MC and IPC approved claims with process date December 2009
  - FY07-08 includes SD/MC and IPC approved claims with process date April 2009
  - FY06-07 includes SD/MC and IPC approved claims with process date May 2008
  - FY05-06 includes SD/MC and IPC approved claims with process date October 2007
  - FY04-05 includes SD/MC and IPC approved claims with process date April 2006
  - FY03-04 includes SD/MC and IPC approved claims with process date October 2005
  - FY02-03 includes SD/MC and IPC approved claims as of final reconciliation
  - FY08-09 denials include SD/MC claims (not IPC claims) processed between July 1, 2008 and June 30, 2009 (without regard to service date) with process date November 2009. Same methodology is used for prior years.
  - Most recent MMEF includes Medi-Cal eligibility for April 2010 and 15 prior months

- **Data Definitions:** Selected elements displayed in many figures within this report are defined below.
  - Penetration rate – The number of Medi-Cal beneficiaries served per year divided by the average number of Medi-Cal eligibles per month. The denominator is the monthly average of Medi-Cal eligibles over a 12-month period.
  - Approved claims per beneficiary served per year – The annual dollar amount of approved claims divided by the unduplicated number of Medi-Cal beneficiaries served per year

- **MHP Size:** Categories are based upon DMH definitions by county population.
  - Small-Rural MHPs = Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Plumas, Siskiyou, Trinity
  - Small MHPs = El Dorado, Humboldt, Imperial, Kings, Lake, Madera, Mendocino, Napa, Nevada, San Benito, Shasta, Sutter/Yuba, Tehama, Tuolumne
  - Medium MHPs = Butte, Marin, Merced, Monterey, Placer/Sierra, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Yolo
  - Large MHPs = Alameda, Contra Costa, Fresno, Kern, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Ventura
  - Los Angeles' statistics are excluded from size comparisons, but are included in statewide data.

D. Attachment— Medi-Cal Approved Claims Worksheets and Additional Tables

Medi-Cal Approved Claims Data for SAN DIEGO County MHP Calendar Year 10

Significant Claims Lag May Exist Due to SD/MC Phase II Processing Issues. The Claims Lag Varies across the MHPs.

Date Prepared:	12/07/2011, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/02/2011, 11/09/2011, and 04/04/2011 - Note (3)
Important Changes:	Note (5)

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	409,838	30,051	$94,223,185	7.33%	$3,135	5.87%	$4,288	5.86%	$4,685
AGE GROUP									
0-5	77,180	1,767	$2,387,308	2.29%	$1,351	1.59%	$3,583	1.65%	$3,705
6-17	111,407	10,715	$47,327,716	9.62%	$4,417	7.50%	$5,475	7.75%	$6,064
18-59	151,524	15,210	$39,640,746	10.04%	$2,606	7.87%	$3,788	7.52%	$4,086
60+	69,729	2,359	$4,867,416	3.38%	$2,063	3.31%	$2,820	3.38%	$2,945
GENDER									
Female	231,529	15,408	$40,784,821	6.65%	$2,647	5.35%	$3,764	5.31%	$4,181
Male	178,309	14,643	$53,438,364	8.21%	$3,649	6.52%	$4,838	6.57%	$5,206
RACE/ETHNICITY									
White	88,125	11,459	$34,353,596	13.00%	$2,998	10.94%	$4,137	10.64%	$4,732

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Hispanic	201,846	9,974	$31,001,944	4.94%	$3,108	3.51%	$3,918	3.58%	$4,446
African-American	37,717	3,997	$15,630,000	10.60%	$3,910	10.08%	$5,147	10.45%	$5,055
Asian/Pacific Islander	38,894	1,904	$3,879,623	4.90%	$2,038	4.07%	$3,446	4.13%	$3,626
Native American	1,610	214	$991,517	13.29%	$4,633	11.93%	$4,865	10.15%	$5,128
Other	41,648	2,503	$8,366,505	6.01%	$3,343	5.87%	$5,428	6.30%	$5,866
ELIGIBILITY CATEGORIES									
Disabled	74,928	13,622	$41,846,618	18.18%	$3,072	17.73%	$4,407	18.07%	$4,660
Foster Care	3,525	2,497	$15,820,024	70.84%	$6,336	58.13%	$7,213	62.53%	$7,514
Other Child	177,597	9,569	$28,977,799	5.39%	$3,028	4.02%	$4,012	4.22%	$4,482
Family Adult	82,707	4,481	$5,641,393	5.42%	$1,259	4.04%	$1,999	3.85%	$2,328
Other Adult	71,313	727	$1,937,352	1.02%	$2,665	1.00%	$3,056	1.00%	$3,060
SERVICE CATEGORIES									
Inpatient Services	409,838	2,628	$18,600,118	0.64%	$7,078	0.48%	$7,977	0.46%	$8,099
Residential Services	409,838	717	$2,226,701	0.17%	$3,106	0.07%	$7,932	0.06%	$8,051
Crisis Stabilization	409,838	899	$940,518	0.22%	$1,046	0.44%	$1,809	0.33%	$1,669
Day Treatment	409,838	1,171	$11,343,111	0.29%	$9,687	0.10%	$11,025	0.08%	$11,703
Case Management	409,838	7,983	$6,332,084	1.95%	$793	2.30%	$951	2.52%	$859
Mental Health Serv.	409,838	23,196	$39,158,902	5.66%	$1,688	4.49%	$2,732	4.67%	$3,121
Medication Support	409,838	13,882	$10,189,928	3.39%	$734	3.05%	$987	3.02%	$1,167
Crisis Intervention	409,838	1,575	$1,050,078	0.38%	$667	0.47%	$760	0.63%	$929
TBS	409,838	508	$4,381,745	0.12%	$8,625	0.09%	$11,210	0.07%	$12,968

Footnotes:

1 - Includes approved claims data on MHP eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 301,175

5 - Beginning with CY10 data, CAEQRO made the following Service Category Changes:

- "24 Hours Services" is no longer a unique service category. The components of "24 Hours Services" are reported as "Inpatient Services" or "Residential Services"
- "23 Hours Services" has been relabeled "Crisis Stabilization", which includes Urgent Care
- "Linkage/Brokerage" has been relabeled "Case Management"
- "Outpatient Services" is no longer a unique service category. The components of "Outpatient Services" are reported as "Mental Health Serv." or "Crisis Intervention"

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY10

Number of Services Approved per Beneficiary Served	SAN DIEGO			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	2,666	8.87	8.87	9.54	9.54	4.82	17.70
2 services	2,218	7.38	16.25	6.46	16.00	4.03	15.00
3 services	2,729	9.08	25.33	5.67	21.67	2.40	10.00
4 services	2,060	6.86	32.19	5.00	26.66	0.00	8.11
5 - 15 services	11,067	36.83	69.02	32.92	59.58	21.23	41.36
> 15 services	9,311	30.98	100.00	40.42	100.00	19.37	59.59

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/02/2011; Inpatient Consolidation approved claims as of 11/09/2011

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Medi-Cal Approved Claims Data for SAN DIEGO County MHP Calendar Year 10

Foster Care

Significant Claims Lag May Exist Due to SD/MC Phase II Processing Issues. The Claims Lag Varies across the MHPs.

Date Prepared:	12/09/2011, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/02/2011, 11/09/2011, and 04/04/2011 - Note (3)
Important Changes:	Note (5)

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	3,525	2,497	$15,820,024	70.84%	$6,336	58.13%	$7,213	62.53%	$7,514
AGE GROUP									
0-5	1,080	646	$794,252	59.81%	$1,229	36.16%	$3,246	43.46%	$3,353
6+	2,446	1,851	$15,025,772	75.67%	$8,118	65.81%	$7,975	69.17%	$8,425
GENDER									
Female	1,715	1,168	$6,690,292	68.10%	$5,728	56.66%	$7,031	60.65%	$7,378
Male	1,811	1,329	$9,129,732	73.38%	$6,870	59.54%	$7,379	64.31%	$7,636
RACE/ETHNICITY									
White	963	744	$4,525,620	77.26%	$6,083	63.82%	$7,115	53.81%	$8,321

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Hispanic	1,464	1,023	$5,665,663	69.88%	$5,538	55.60%	$5,878	74.30%	$6,029
African-American	830	587	$4,736,510	70.72%	$8,069	58.57%	$8,627	69.75%	$8,105
Asian/Pacific Islander	132	78	$502,665	59.09%	$6,444	66.63%	$8,551	71.84%	$8,003
Native American	67	41	$261,806	61.19%	$6,386	54.57%	$6,074	46.72%	$7,263
Other	71	24	$127,760	33.80%	$5,323	27.91%	$14,537	39.35%	$11,690
SERVICE CATEGORIES									
Inpatient Services	3,525	94	$407,269	2.67%	$4,333	1.98%	$8,427	2.42%	$8,376
Residential Services	3,525	1	$1,111	0.03%	$1,111	0.01%	$1,972	0.01%	$3,695
Crisis Stabilization	3,525	28	$23,564	0.79%	$842	1.48%	$1,199	1.13%	$1,285
Day Treatment	3,525	613	$6,224,411	17.39%	$10,154	3.66%	$12,392	2.96%	$12,300
Case Management	3,525	504	$223,578	14.30%	$444	24.40%	$1,329	28.81%	$991
Mental Health Serv.	3,525	2,257	$6,369,836	64.03%	$2,822	54.59%	$4,795	59.76%	$5,159
Medication Support	3,525	862	$1,003,758	24.45%	$1,164	18.44%	$1,248	19.57%	$1,543
Crisis Intervention	3,525	154	$173,166	4.37%	$1,124	3.20%	$1,048	4.15%	$1,420
TBS	3,525	163	$1,393,332	4.62%	$8,548	3.23%	$10,830	3.09%	$12,533

Footnotes:

1 - Includes approved claims data on MHP eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 2,852

5 - Beginning with CY10 data, CAEQRO made the following Service Category Changes:

- "24 Hours Services" is no longer a unique service category. The components of "24 Hours Services" are reported as "Inpatient Services" or "Residential Services"
- "23 Hours Services" has been relabeled "Crisis Stabilization", which includes Urgent Care
- "Linkage/Brokerage" has been relabeled "Case Management"
- "Outpatient Services" is no longer a unique service category. The components of "Outpatient Services" are reported as "Mental Health Serv." or "Crisis Intervention"

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY10

Foster Care

	SAN DIEGO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	75	3.00	3.00	6.39	6.39	0.00	22.42
2 services	137	5.49	8.49	5.19	11.57	0.00	16.72
3 services	392	15.70	24.19	4.57	16.14	0.00	15.70
4 services	178	7.13	31.32	3.66	19.80	0.00	15.15
5 - 15 services	542	21.71	53.02	26.10	45.90	6.67	42.86
> 15 services	1,173	46.98	100.00	54.10	100.00	28.57	80.00

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/02/2011; Inpatient Consolidation approved claims as of 11/09/2011

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

Medi-Cal Approved Claims Data for SAN DIEGO County MHP Calendar Year 10

Transition Age Youth (Age 16-25)

Significant Claims Lag May Exist Due to SD/MC Phase II Processing Issues. The Claims Lag Varies across the MHPs.

Date Prepared:	12/08/2011, Version 1.0
Prepared by:	Hui Zhang, APS Healthcare / CAEQRO
Data Sources:	DMH Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	11/02/2011, 11/09/2011, and 04/04/2011 - Note (3)
Important Changes:	Note (5)

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
TOTAL									
	58,512	5,116	$23,054,272	8.74%	$4,506	6.99%	$5,396	7.03%	$5,792
AGE GROUP									
16-17	18,132	2,323	$12,992,991	12.81%	$5,593	10.02%	$6,324	10.31%	$6,739
18-21	26,633	1,906	$7,711,145	7.16%	$4,046	6.21%	$4,886	6.22%	$5,275
22-25	13,748	887	$2,350,136	6.45%	$2,650	4.91%	$4,356	4.70%	$4,610
GENDER									
Female	34,546	2,483	$9,797,912	7.19%	$3,946	5.82%	$5,004	5.85%	$5,489
Male	23,966	2,633	$13,256,360	10.99%	$5,035	8.73%	$5,784	8.75%	$6,086
RACE/ETHNICITY									
White	10,389	1,663	$6,918,278	16.01%	$4,160	12.20%	$5,107	12.54%	$5,986

	SAN DIEGO					LARGE		STATEWIDE	
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year	Penetration Rate	Approved Claims per Beneficiary Served per Year
Hispanic	31,943	2,142	$9,577,428	6.71%	$4,471	4.82%	$4,898	4.90%	$5,334
African-American	6,865	798	$4,137,821	11.62%	$5,185	11.31%	$6,073	11.17%	$5,920
Asian/Pacific Islander	4,004	179	$866,983	4.47%	$4,843	3.70%	$6,074	3.71%	$6,165
Native American	254	28	$225,072	11.02%	$8,038	10.60%	$6,240	10.40%	$6,138
Other	5,061	306	$1,328,690	6.05%	$4,342	7.21%	$7,169	7.55%	$7,763
ELIGIBILITY CATEGORIES									
Disabled	6,232	1,402	$5,785,905	22.50%	$4,127	20.71%	$6,236	21.70%	$6,565
Foster Care	800	733	$6,374,856	91.63%	$8,697	73.85%	$8,360	80.74%	$8,328
Other Child	16,438	1,724	$6,734,144	10.49%	$3,906	7.85%	$4,538	8.16%	$4,927
Family Adult	28,305	1,285	$3,039,391	4.54%	$2,365	3.97%	$2,925	4.12%	$3,329
Other Adult	6,841	283	$1,119,977	4.14%	$3,958	3.16%	$4,127	2.85%	$4,174
SERVICE CATEGORIES									
Inpatient Services	58,512	649	$3,475,826	1.11%	$5,356	0.86%	$7,562	0.83%	$7,356
Residential Services	58,512	75	$166,898	0.13%	$2,225	0.06%	$7,860	0.06%	$8,543
Crisis Stabilization	58,512	195	$221,234	0.33%	$1,135	0.73%	$1,499	0.53%	$1,471
Day Treatment	58,512	512	$5,409,864	0.88%	$10,566	0.22%	$11,263	0.18%	$11,565
Case Management	58,512	1,423	$1,131,439	2.43%	$795	2.79%	$1,168	3.09%	$968
Mental Health Serv.	58,512	4,158	$9,671,793	7.11%	$2,326	5.62%	$3,315	5.82%	$3,815
Medication Support	58,512	2,241	$1,748,997	3.83%	$780	3.20%	$1,015	3.15%	$1,210
Crisis Intervention	58,512	412	$356,065	0.70%	$864	0.77%	$827	0.98%	$963
TBS	58,512	100	$872,155	0.17%	$8,722	0.13%	$10,486	0.12%	$10,923

Footnotes:

1 - Includes approved claims data on MHP eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the reported calendar year

4 - County total number of yearly unduplicated Medi-Cal eligibles is 48,778

5 - Beginning with CY10 data, CAEQRO made the following Service Category Changes:

- "24 Hours Services" is no longer a unique service category. The components of "24 Hours Services" are reported as "Inpatient Services" or "Residential Services"
- "23 Hours Services" has been relabeled "Crisis Stabilization", which includes Urgent Care
- "Linkage/Brokerage" has been relabeled "Case Management"
- "Outpatient Services" is no longer a unique service category. The components of "Outpatient Services" are reported as "Mental Health Serv." or "Crisis Intervention"

SAN DIEGO County MHP Medi-Cal Services Retention Rates CY10

Transition Age Youth (Age 16-25)

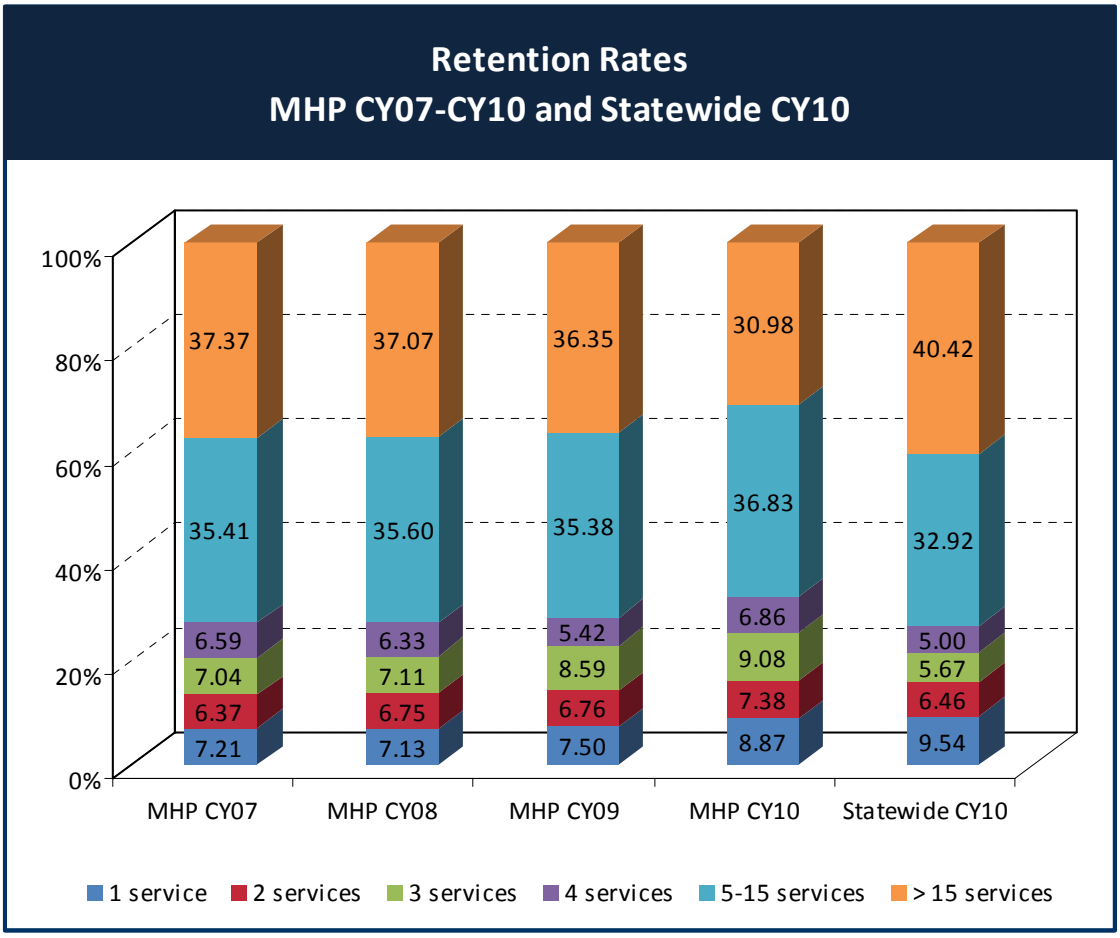
	SAN DIEGO			STATEWIDE			
Number of Services Approved per Beneficiary Served	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	427	8.35	8.35	10.42	10.42	0.00	26.23
2 services	370	7.23	15.58	6.60	17.02	0.00	18.87
3 services	347	6.78	22.36	5.34	22.36	0.00	13.53
4 services	298	5.82	28.19	4.50	26.86	0.00	11.69
5 - 15 services	1,703	33.29	61.47	29.41	56.27	21.28	50.00
> 15 services	1,971	38.53	100.00	43.73	100.00	14.29	59.57

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/02/2011; Inpatient Consolidation approved claims as of 11/09/2011

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

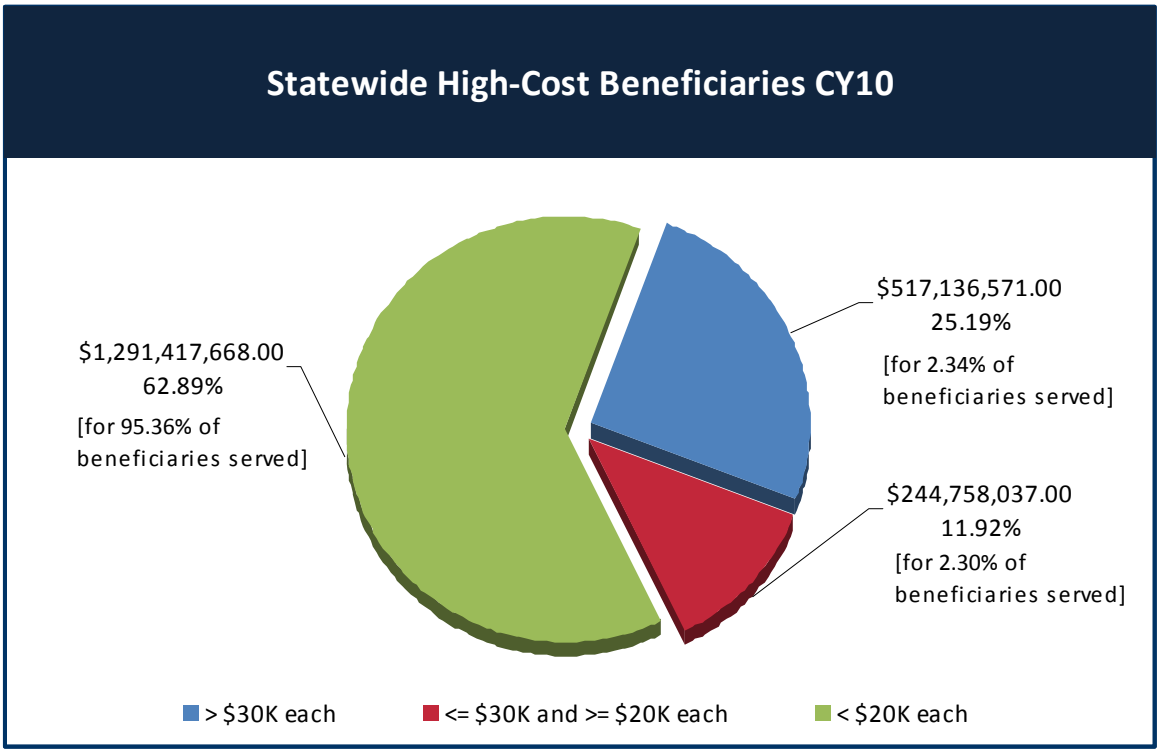
Retention Rates

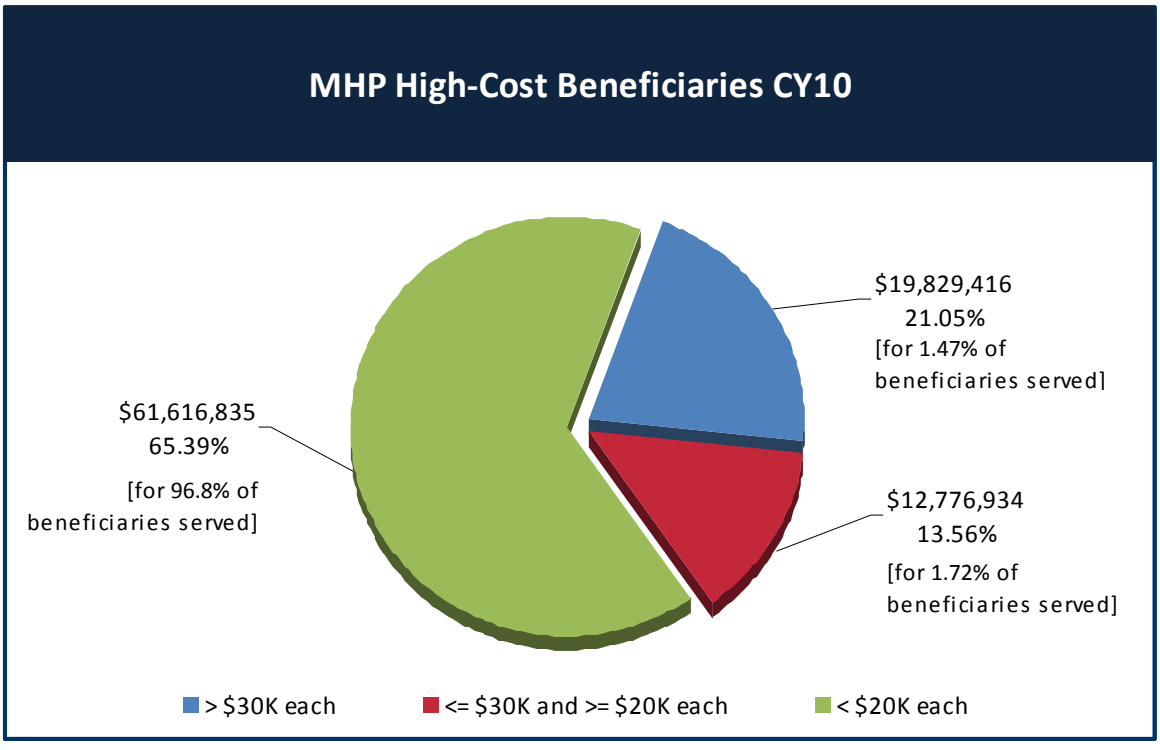


CY2010 Retention Rates with Average Approved Claims per Category

Number of Services Approved per Beneficiary Served	MHP Number of beneficiaries served	MHP $ per beneficiary served	Statewide $ per beneficiary served
1 service	2,666	$159	$294
2 services	2,218	$275	$452
3 services	2,729	$437	$600
4 services	2,060	$505	$735
5 – 15 services	11,067	$1,090	$1,518
> 15 services	9,311	$8,473	$10,040

High Cost Beneficiaries CY10





EXAMINATION OF DISPARITIES

Statewide disparities remain for Hispanic and female beneficiaries:

- The relative access and the average approved claims for Hispanic beneficiaries were lower than for White beneficiaries. Over the past four years of data, these disparities decreased slightly – approaching parity in approved claims but a continued remarkable disparity in access.
- The relative access and the average approved claims for female beneficiaries were lower than for males. These disparities have remained stable over the last four years.

For each variable (Hispanic/White and female/male), two ratios are calculated to depict relative access and relative approved claims. The first figure compares approved claims data and penetration rates between Hispanic and White beneficiaries. This penetration rate ratio is calculated by dividing the Hispanic penetration rate by the White penetration rate, resulting in a ratio that depicts the relative access for Hispanics when compared to Whites. The approved claims ratio is calculated by dividing the average approved claims for Hispanics by the average approved claims for Whites. Similar calculations follow in the second figure for female to male beneficiaries.

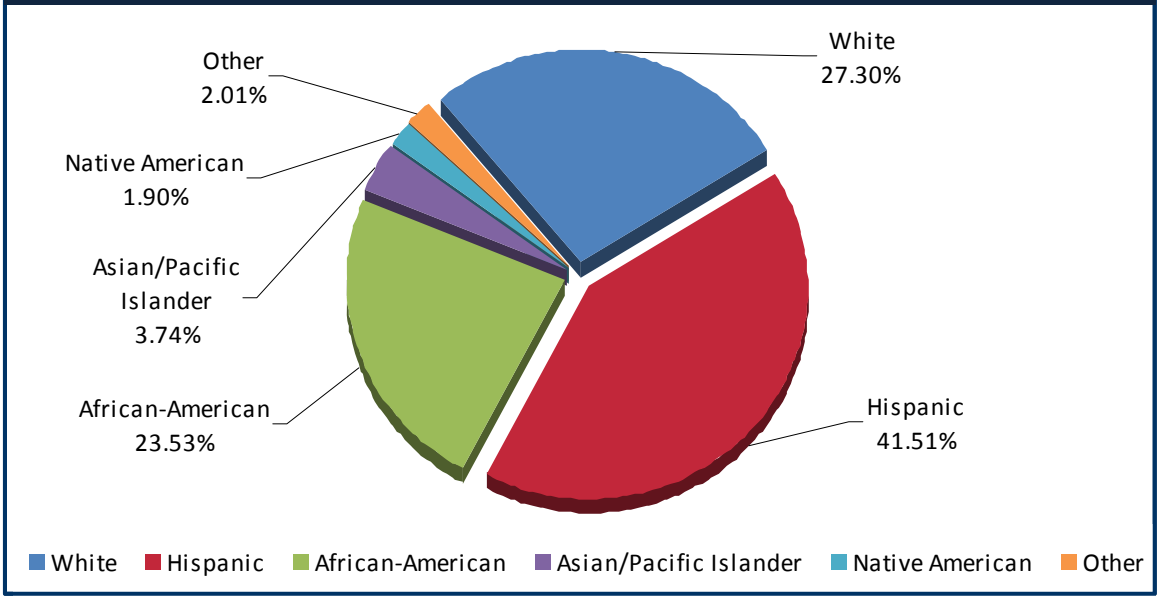
For all elements, ratios depict the following:

- 1.0 = parity between the two elements compared
- Less than 1.0 = disparity for Hispanics or females
- Greater than 1.0 = no disparity for Hispanics or females. A ratio of greater than one indicates higher penetration or approved claims for Hispanics when compared to Whites or for females when compared to males.

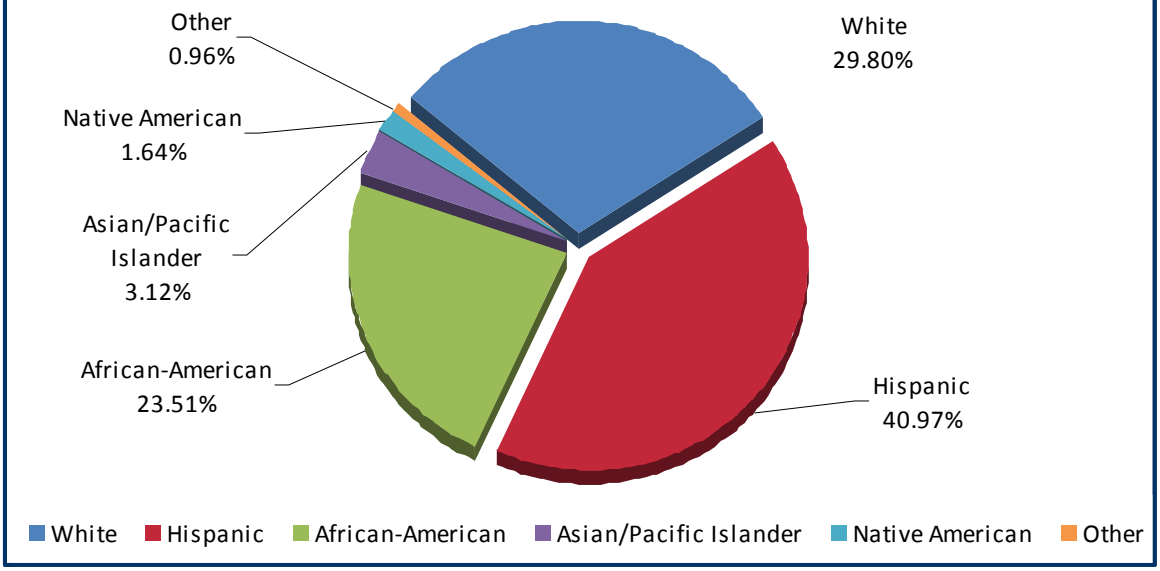
Examination of Disparities—Hispanic versus White								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY10	147,057	3.58%	157,588	10.64%	$4,446	$4,732	.34	.94
MHP CY10	9,974	4.94%	11,459	13.00%	$3,108	$2,998	.38	1.04
MHP CY09	9,938	5.03%	12,166	13.61%	$3,266	$3,263	.37	1.00
MHP CY08	9,618	5.31%	12,530	14.58%	$3,123	$3,113	.36	1.00
MHP CY07	9,192	5.24%	12,361	14.39%	$3,303	$3,274	.36	1.01

Examination of Disparities—Female versus Male								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Female versus Male for	
	Female		Male		Female	Male	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
Statewide CY10	222,624	5.31%	215,606	6.57%	$4,181	$5,206	.81	.80
MHP CY10	15,408	6.65%	14,643	8.21%	$2,647	$3,649	.81	.73
MHP CY09	16,610	7.13%	15,154	8.65%	$2,905	$3,757	.82	.77
MHP CY08	16,766	7.70%	15,078	9.38%	$2,776	$3,577	.82	.78
MHP CY07	16,363	7.73%	14,571	9.37%	$2,860	$3,864	.82	.74

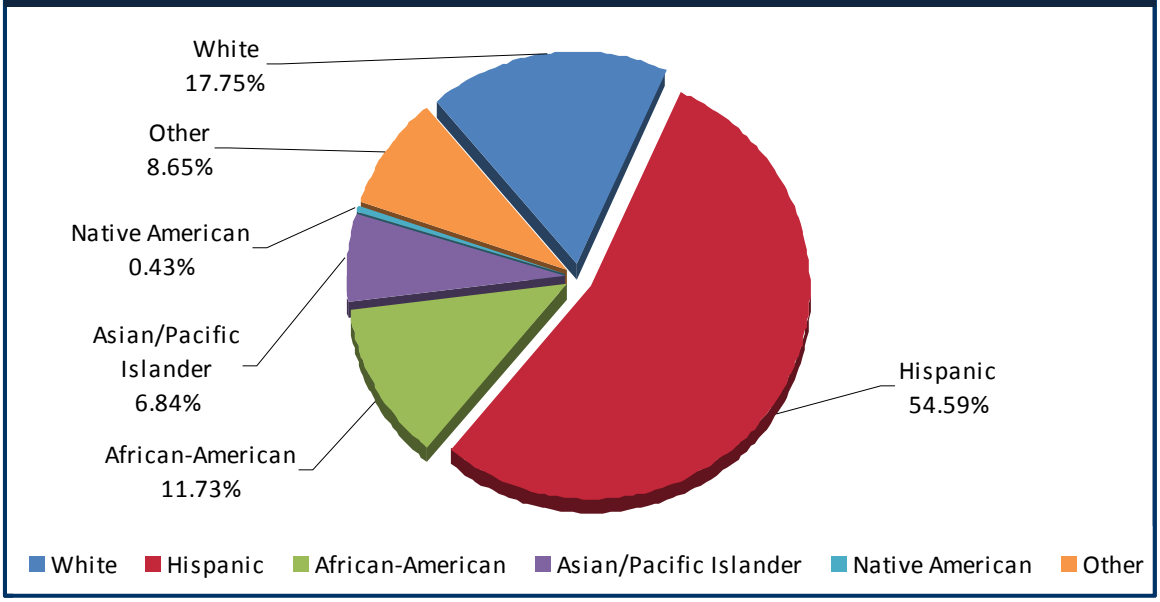
MHP Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Foster Care CY10



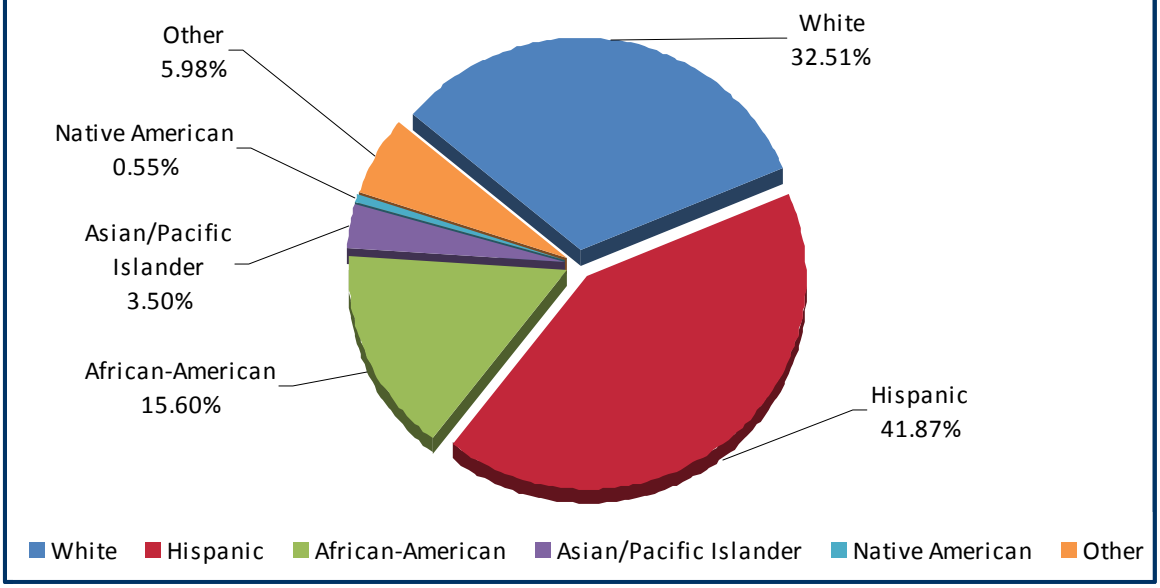
MHP Medi-Cal Beneficiaries Served, by Race/Ethnicity - Foster Care CY10



MHP Medi-Cal Average Monthly Unduplicated Eligibles, by Race/Ethnicity - Transition Age Youth CY10



MHP Medi-Cal Beneficiaries Served, by Race/Ethnicity - Transition Age Youth CY10



E. Attachment—PIP Validation Tool

FY11-12 Review of: San Diego ☒ Clinical ☐ Non-Clinical

PIP Title: EPSDT

Date PIP Began: 2008

PIP Category: ☐Access ☐Timeliness ☐Quality ☒Outcomes ☐Other

Descriptive Category: Improved diagnosis or treatment processes

Target Population: Other: Foster youth ages 0-5 and EPSDT consumers who meet the threshold cost criteria of $3,000 for three months and who entered services at age 7 and younger

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
1	**Study topic** *The study topic:*					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	X				
1.2	Was selected following data collection and analysis of data that supports the identified problem	X				
1.3	Addresses key aspects of care and services	X				
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs	X				
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X				
Totals for Step 1:		**5**	**0**	**0**	**0**	
2	**Study Question Definition** *The written study question: Will implementing activities such as identification of predictors of high service utilization and the development of appropriate early childhood interventions lead to enhanced quality, effectiveness, and efficiency of service*					

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	delivery to children, ages 0-5, receiving EPSDT funded mental health services?					
2.1	Identifies the problem targeted for improvement	X				
2.2	Includes the specific population to be addressed	X				
2.3	Includes a general approach to interventions	X				
2.4	Is answerable/demonstrable	X				
2.5	Is within the MHP's scope of influence	X				
Totals for Step 2:		**5**	**0**	**0**	**0**	
3	**Clearly Defined Study Indicators** *The study indicators:*					
3.1	Are clearly defined, objective, and measurable	X				
3.2	Are designed to answer the study question	X				
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X				
3.4	Have accessible data that can be collected for each indicator		X			Baselines not available for all indicators
3.5	Utilize existing baseline data that demonstrate the current status for each indicator		X			See 3.2
3.6	Identify relevant benchmarks for each indicator			X		No benchmarks defined.
3.7	Identify a specific, measurable goal(s) for each indicator			X		Many goals approximate.
Totals for Step 3:		**3**	**2**	**2**		
4	**Correctly Identified Study Population** *The method for identifying the study population:*					
4.1	Is accurately and completely defined	X				
4.2	Included a data collection approach that captures all consumers for whom the study question applies			X		Appears that the data collection strategy does not fit the realities of the population (multiple caregivers, highly mobile population.)
Totals for Step 4:		**1**	**0**	**1**		

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
5	**Use of Valid Sampling Techniques** *The sampling techniques:*					
5.1	Consider the true or estimated frequency of occurrence in the population				X	No sampling strategy employed.
5.2	Identify the sample size				X	No sampling strategy employed
5.3	Specify the confidence interval to be used				X	No sampling strategy employed
5.4	Specify the acceptable margin of error				X	No sampling strategy employed
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population				X	No sampling strategy employed
Totals for Step 5:		**0**	**0**	**0**	**5**	No sampling strategy employed
6	**Accurate/Complete Data Collection** *The data techniques:*					
6.1	Identify the data elements to be collected	X				
6.2	Specify the sources of data	X				
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X				
6.4	Provides a timeline for the collection of baseline and remeasurement data	X				
6.5	Identify qualified personnel to collect the data	X				
Totals for Step 6:		**5**	**0**	**0**	**0**	
7	**Appropriate Intervention and Improvement Strategies** *The planned/implemented intervention(s) for improvement:*					
7.1	Are related to causes/barriers identified through data analyses and QI processes	X				
7.2	Have the potential to be applied system wide to induce significant change	X				As age-appropriate: Interventions specific to 0-5 foster care youth.
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful			X		unknown
7.4	Are standardized and monitored when an intervention is successful			X		Relatively new program, not yet ready for widespread standardization.
Totals for Step 7:		**2**	**0**	**2**	**0**	

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
8	**Analyses of Data and Interpretation of Study Results** *The data analyses and study results:*					
8.1	Are conducted according to the data analyses plan in the study design	X				
8.2	Identify factors that may threaten internal or external validity	X				
8.3	Are presented in an accurate, clear, and easily understood fashion	X				
8.4	Identify initial measurement and remeasurement of study indicators	X				
8.5	Identify statistical differences between initial measurement and remeasurement	X				
8.6	Include the interpretation of findings and the extent to which the study was successful	X				
Totals for Step 8:		**6**	**0**	**0**	**0**	
9	**Improvement Achieved** *There is evidence for true improvement based on:*					
9.1	A consistent baseline and remeasurement methodology	X				
9.2	Documented quantitative improvement in processes or outcomes of care	X				
9.3	Improvement appearing to be the result of the planned interventions(s)	X				
9.4	Statistical evidence for improvement	X				
Totals for Step 9:		**4**	**0**	**0**	**0**	
10	**Sustained Improvement Achieved** *There is evidence for sustained improvement based on:*					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			X		
Totals for Step 10:				**1**		

FY11-12 Review of: San Diego ☐ Clinical ☒ Non-Clinical

PIP Title: Mental Illness Stigma Reduction Media Campaign

Date PIP Began: April 2010

Date PIP Completed

PIP Category: ☐Access ☐Timeliness ☐Quality ☐Outcomes ☒Other

Descriptive Category: Other

Target Population: All Population

Step		Rating				Comments/Recommendations
		Met	**Partial**	**Not Met**	**N/A**	
1	**Study topic** *The study topic:*					
1.1	Focuses on an identified problem that reflects high volume, high risk conditions, or underserved populations	**X**				
1.2	Was selected following data collection and analysis of data that supports the identified problem	**X**				
1.3	Addresses key aspects of care and services	**X**				Recognition of MI symptoms as source of distress vital to identification of proper sources of help. Societal stigma impacts acceptability of tx as well as overall QOL of individuals with SMI>
1.4	Includes all eligible populations that meet the study criteria, and does not exclude consumers with special needs	**X**				
1.5	Has the potential to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	**X**				
Totals for Step 1:		**5**	**0**	**0**	**0**	
2	**Study Question Definition** *The written study question: Is a comprehensive, multi-media education campaign an effective method to improve public awareness and knowledge about mental illness and an effective vehicle to help decrease stigma and discrimination about persons with mental illness?*					

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
2.1	Identifies the problem targeted for improvement	X				
2.2	Includes the specific population to be addressed	X				
2.3	Includes a general approach to interventions	X				
2.4	Is answerable/demonstrable	X				
2.5	Is within the MHP's scope of influence	X				Contracted with AdEASE and Cook & Schmid for PR
Totals for Step 2:		**5**	**0**	**0**	**0**	
3	**Clearly Defined Study Indicators** *The study indicators:*					
3.1	Are clearly defined, objective, and measurable	X				Mental Health Literacy Scale, Lack of Social Distancing Scale, Mental Health Openness Scale, Mental Health Knowledge & Access Scale
3.2	Are designed to answer the study question	X				
3.3	Are identified to measure changes designed to improve consumer mental health outcomes, functional status, satisfaction, or related processes of care designed to improve same	X				Addressing barriers to problem identification, treatment seeking and social support.
3.4	Have accessible data that can be collected for each indicator	X				Telephonic surveys of n = 602 at baseline and follow up at yearly intervals.
3.5	Utilize existing baseline data that demonstrate the current status for each indicator	X				
3.6	Identify relevant benchmarks for each indicator	X				
3.7	Identify a specific, measurable goal(s) for each indicator	X				
Totals for Step 3:		**7**	**0**	**0**	**0**	
4	**Correctly Identified Study Population** *The method for identifying the study population:*					
4.1	Is accurately and completely defined	X				
4.2	Included a data collection approach that captures all consumers for whom the study question applies	X				Representative Sample
Totals for Step 4:		**2**	**0**	**0**	**0**	

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
5	**Use of Valid Sampling Techniques** *The sampling techniques:*					
5.1	Consider the true or estimated frequency of occurrence in the population	X				Random sample achieved through Random Digit Dialing of mix of mobile and landline phones, towards end of data collection sampling adjusted to obtain demographically representative sample.
5.2	Identify the sample size	X				602
5.3	Specify the confidence interval to be used	X				95%
5.4	Specify the acceptable margin of error	X				+/- 4 %
5.5	Ensure a representative and unbiased sample of the eligible population that allows for generalization of the results to the study population	X				
Totals for Step 5:		**5**	**0**	**0**	**0**	
6	**Accurate/Complete Data Collection** *The data techniques:*					
6.1	Identify the data elements to be collected	X				
6.2	Specify the sources of data	X				
6.3	Outline a defined and systematic process that consistently and accurately collects baseline and remeasurement data	X				
6.4	Provides a timeline for the collection of baseline and remeasurement data	X				
6.5	Identify qualified personnel to collect the data	X				
Totals for Step 6:		**5**	**0**	**0**	**0**	
7	**Appropriate Intervention and Improvement Strategies** *The planned/implemented intervention(s) for improvement:*					
7.1	Are related to causes/barriers identified through data analyses and QI processes	X				
7.2	Have the potential to be applied system wide to induce significant change	x			x	
7.3	Are tied to a contingency plan for revision if the original intervention(s) is not successful	X				Impact of ads assessed, those with least impact phased out, etc
7.4	Are standardized and monitored when an	X				

Step		Rating				Comments/Recommendations
		Met	Partial	Not Met	N/A	
	intervention is successful					
Totals for Step 7:		**4**	**0**	**0**	**0**	
8	**Analyses of Data and Interpretation of Study Results** *The data analyses and study results:*					
8.1	Are conducted according to the data analyses plan in the study design	**X**				
8.2	Identify factors that may threaten internal or external validity	**X**				
8.3	Are presented in an accurate, clear, and easily understood fashion	**X**				
8.4	Identify initial measurement and remeasurement of study indicators	**X**				
8.5	Identify statistical differences between initial measurement and remeasurement	**X**				
8.6	Include the interpretation of findings and the extent to which the study was successful	**X**				
Totals for Step 8:		**6**	**0**	**0**	**0**	
9	**Improvement Achieved** *There is evidence for true improvement based on:*					
9.1	A consistent baseline and remeasurement methodology	**X**				
9.2	Documented quantitative improvement in processes or outcomes of care	**X**				
9.3	Improvement appearing to be the result of the planned interventions(s)	**X**				
9.4	Statistical evidence for improvement	**X**				
Totals for Step 9:		**4**	**0**	**0**	**0**	
10	**Sustained Improvement Achieved** *There is evidence for sustained improvement based on:*					
	Repeated measurements over comparable time periods that demonstrate sustained improvement, or that any decline in improvement is not statistically significant			**X**		Measurement cycles are one year. Next remeasurement 3/2012.
Totals for Step 10:		**0**	**0**	**1**	**0**	

F. Attachment—MHP PIPs Submitted

APS HEALTHCARE
Healthy Together
California EQRO
560 J Street, Suite 390

CAEQRO PIP Outline via Road Map – EPSDT PIP

Sacramento, CA 95814

MHP: San Diego County Behavioral Health Services, Children's Mental Health
Date PIP Began: Nov 1, 2008
Title of PIP: EPSDT PIP
Clinical or Non-Clinical: Clinical

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.

MHP Level Committee: List local PIP committee members including their position and affiliation.

The following table lists San Diego County's EPSDT PIP stakeholder committee members including their position and affiliation:

Name	Affiliation	Position
Alexander, Tom	Fred Finch Youth Center	Program Director
Anderson, Kathy	County of San Diego Behavioral Health Services	Performance Outcomes Principal Administrative Analyst
Astor, Katie	County of San Diego-Children's Mental Health Services	Outpatient Services and Therapeutic Behavioral Services Chief
Chadwick, Amy	Child & Adolescent Services Research Center	System of Care Evaluation Coordinator
Culver, Shirley	San Diego Unified School District Special Education	Children's Mental Health Services System of Care Council-Performance Outcomes Committee Chair
Danon, Patty Kay	County of San Diego Child Welfare Services	Adolescent/Residential/Special Services Assistant Deputy Director

Name	Affiliation	Position
Engelman, Celia	County of San Diego Mental Health Services	Quality Improvement Specialist
Fox, Barry	County of San Diego Child Welfare Services	Residential Services Chief
Frink, Kim	County of San Diego Child Welfare Services	Health Planning and Program Specialist
Ganger, Bill	Child & Adolescent Services Research Center	Statistician
Garland, Ann	Child & Adolescent Services Research Center	Associate Director
Lea, Samantha	County of San Diego Behavioral Health Services	Performance Outcomes Project Analyst
Leal, Melinda	County of San Diego Children's Mental Health Services	Therapeutic Behavioral Services Program Manager
Lewis, Marshall	County of San Diego Behavioral Health Services	Clinical Director
Marto, Donna	Family and Youth Roundtable CEO	Children's Mental Health Family Liaison
Messel, Ryan	Family and Youth Roundtable Communications Coordinator	Children's Mental Health Services System of Care Council-Performance Outcomes Committee
Milow, Candace	County of San Diego Behavioral Health Services	Quality Improvement Director
Myers, Roseann	County of San Diego Children's Mental Health Services	Policy and Program Support Assistant Deputy Director
Peleska, Theresa	County of San Diego Child Welfare Services	Residential Services Protective Services Supervisor
Picker, Jamie	County of San Diego Children's Mental Health Services	Emergency Screening Unit Program Manager
Rowe, Jeff	County of San Diego Behavioral Health Services	Supervising Psychiatrist
Trask, Emily	Child & Adolescent Services Research Center	Senior Mental Health Researcher

"Is there really a problem?"

2. Define the problem by describing the data reviewed and relevant benchmarks. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.

Statewide: Approved EPSDT claims data for FY 2006-07 shows that the 3% of EPSDT clients with the highest average monthly claims account for 25.5% of total annual EPSDT spending. While it is reasonable to expect that this highest-cost-of-service cohort includes clients with severe conditions that justify higher average monthly costs, a review of client specific services received by a sample drawn from this cohort often include a complex pattern of use that raises questions about service levels, array of services, possible gaps in service, and multi-system involvement. Studies identified by the Department of Mental Health t of other pediatric health care system highest-cost-of-service cohorts suggest that the cost and complexity of these EPSDT services could indicate a need for improved coordination, enhanced capacity, and other improvements to ensure that each child is receiving services that are indicated, effective, and efficient, at the levels being provided. DMH has consulted with representatives from the California Mental Health Directors Association, the County Welfare Directors Association, the California Council of Community Mental Health Agencies, and the California Alliance of Child and Family Services on the concepts of this proposal as they relate to addressing quality, effectiveness and efficiency of service delivery to children.

MHP: Define local problem – Refer to data examined (include as an attachment if too detailed to add here). If Criterion B, include the MHP's initial dollar threshold for study population inclusion.

Preliminary analysis of high utilizers:
San Diego County Mental Health Services (SDCMHS) agrees with the State Department of Mental Health stakeholders on the importance of further studying the highest-cost-of-service cohorts. After taking a closer look at the 4% of SD clients who were identified by DMH as having a monthly cost for services equal to or greater than $3000 in at least one month in FY0708 (N= 738), SDCMHS determined that the initial focus would be a subset (N=313). This subset of clients have a monthly cost for services equal to or greater than $3000 in at least three months during a fiscal year. A review of our data showed that this subset of clients had a mean cost for services of $33,153 in FY 07-08 (range $11,046 - $106,626) compared to a mean cost of $22,533 for all clients on the high user list provided by the State. The EPSDT service dollars used by this group totaled $10,377,066. A review of client specific services for this subset of EPSDT clients identified questions about service levels and possible gaps in services.

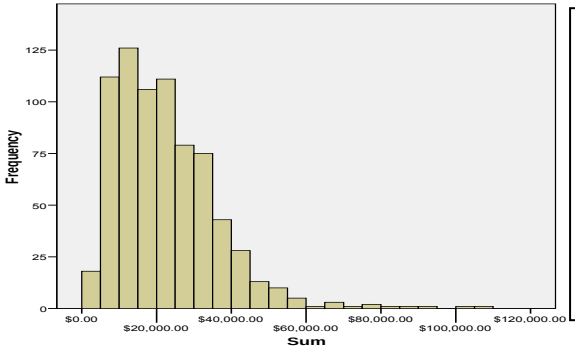
Data and relevant benchmarks:
We chose to focus on clients who used $3000 worth of services in three or more months because these children are likely to have severe and persistent mental health problems. It is possible for a child with mild or moderate mental health problems to have a mental health crisis that requires short-term treatment in high intensity services such as TBS, day treatment, and wraparound. In San Diego, use of one of these services could easily boost the total cost of the children's mental health care to more than $3000 during a single month. However, these children are unlikely to continue to require a costly amount of services once their crisis has abated. In contrast, children who frequently use $3000 worth of services are likely to be significantly impaired and require extensive mental health treatment.

In San Diego County a total of 17,609 EPSDT clients were served in FY 07-08. Of these clients, 4% were identified by DMH as having a monthly cost for services equal to or greater than $3000 in at least one month in FY0708. This represents a baseline of 738 clients. San Diego County completed claims data analysis of all beneficiaries identified by DMH to be high users. The file for this period included claims for 738 clients totaling $16,629,685 service dollars.
Demographics and costs for these clients are described below:

Table 1A – Demographic Characteristics and Comparison with FY 07-08 Children's MH Population

	EPSDT PIP Eligible FY 07-08 (N=738)	All Children's Mental Health System FY 07-08 (N=17,609)
Gender		
Female	36.4%	**39%**
Male	63.2%	**61%**
Race/ Ethnicity		
Hispanic	37.4%	**48%**
White	31.4%	**27%**
African-American	19.8%	**15%**
Asian/Pacific Islander	2.3%	**2%**
Native American	0.4%	**1%**
Other/Unknown	**8.6%**	**7%**

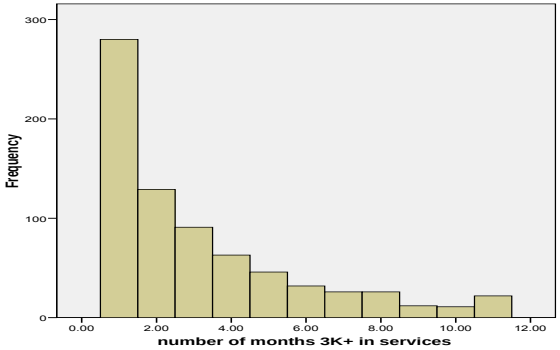
Graph 1A - Average Costs



N= 738
Mean: $22,533
Percentiles:
25th: $12,177.50
50th: $20,308
75th: $30,200.50

- 27 clients spent over $50K
- 7 clients spent over $75K

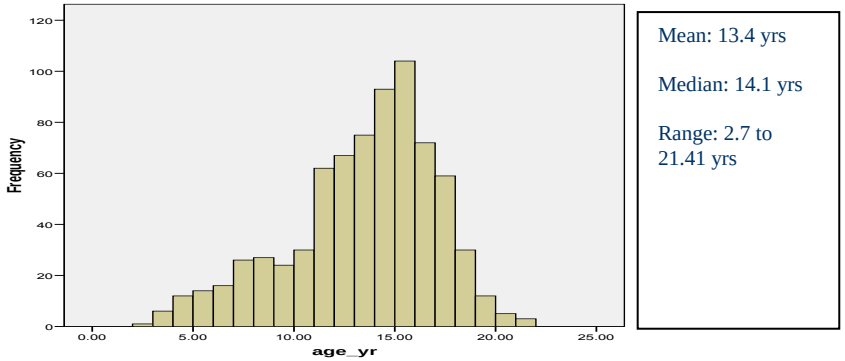
Graph 1B - Months above 3K cutpoint



Mean: 3.2 months at 3K+

- 37.9% of clients reached the 3K cutpoint for 1 month
- 44.6% of clients reached 3K cutpoint for ≥3 months

Graph 1C - Age



Extensive data analyses were carried out to examine these high cost users and determine how they differed, if at all, from the overall Children's Mental Health Services (CMHS) population. We examined service utilization patterns, intensity of service usage, and types of diagnosis. Other than more time in service and more types of services used, no significant difference was found; however, our analyses did show that many of these clients were receiving services from several sectors of care, particularly Special Education and CWS. It was also noted that use of high-end services, such as TBS, Day Treatment, or Wraparound, would automatically boost service billings to over $3,000 during a single month. Since these services are designed to prevent out-of-home placements or ease transition back from a placement, it is reasonable that a child would appropriately enter high end service for a short term (one or two months alone) to ease a critical situation and then move to lower intensity service.

Of the 738 clients on the high-cost list, 37.9% of the clients were shown to have used over $3,000 in services for one month only, while an additional 17.5% of the clients reached the $3,000 cutpoint for two months only, and 44.6% in three or more months. We conducted analyses based on the number of months a client was above the $3,000 cutpoint, using three groups: clients that reached the cutpoint in one month, clients that reached the cutpoint in two months, and clients who reached the cutpoint for three or more months.

Logistic modeling was conducted to identify predictors of high service utilization among the three groups. Across several models, only age at initial service and numbers of episodes per year were significant predictors of being in the three months or higher group. The younger a client entered services, the more likely he/she would become a multiple month high cost utilizer; similarly, higher episode count per year of service also predicted being in the highest cost of service cohort. Data that supports the above findings include mean age at first episode of sample: 7.9 yrs compared to overall system mean of 9.0 yrs and mean episode count per year of service: 5.59 compared to overall system mean of 1.78. In addition, children in the 3+ months above the cutpoint group were significantly more impaired at intake according to the standardized outcomes assessment, and their first episode in services was more likely to occur in the inpatient, emergency screening unit, or residential day treatment setting.

Given these significant statistical differences between the three groups, the EPSDT PIP workgroup decided to initially focus on children who reached the $3K+ threshold for three or more months to determine whether they were receiving the most timely, effective and efficient services. These clients represent 44.6% (N=313) of the initial high cost list. After taking a closer look at this study sample (N=313), data showed that these clients had a mean cost of $33,153 in FY 07-08 (range $11,046 - $106,626) compared to a mean cost of $22,533 for all clients on the high user list (N=738). The EPSDT service dollars used by this group totaled $10,377,066.

Comprehensive analysis of the identified study sample (N=313) revealed even more significant differences when compared to all clients on the high user list (N=738) and the overall CMHS population (N=17609). The data demonstrated that youth in the high cost study group were younger at service entry, had more episode counts overall, used more costly services such as Day Treatment, TBS, and Inpatient, had multiple sector involvement such as Special Education and CWS, and had a much higher bipolar rate when compared to the CMHS population. **Table 2** summarizes these findings.

Table 2 – Striking Differences in Service Utilization Patterns

	All CMHS FY 07-08 (N=17,609)	All High Cost FY 07-08 (N=738)	* High Cost Study Sample (N=313)
Mean Age at First Episode	9.0 yrs (+/- 4.6)	8.14 (+/- 3.6)	**7.9yrs (+/- 3.4)**
Mean Episode Count	4.24 (+/- 6.26)	17.26 (+/- 16.1)	**21.68 (+/- 17.5)**
Mean Episode Count Per Year of Service	1.78 (+/- 1.75)	4.69 (+/- 4.87)	**5.59 (+/- 5.94)**
Mean Cost		$22,533.	**$33,153.40**
Day Treatment Use	~10%	61.8%	**74%**
TBS Use	~2%	25.7%	**32%**
Inpatient Use	~4%	19.4%	**26%**
CWS Involvement	22.3%	54.4%	**51.4%**
Special Education Services	34.8%	68.1%	**73.5%**
Emotional Disturbance	9.6%	38.6%	**49.2%**
Bipolar Diagnosis	**5.2%**	**11.1%**	**22%**

***** Clients reaching the $3K+ threshold for three or more months in 12 month period

While San Diego's findings, thus far, began linking increased severity to the higher average monthly costs for these children, a thorough evaluation of the appropriateness, effectiveness, coordination, and efficiency of service delivery was warranted. In addition, given that younger age at initial entry to the mental health system was significantly associated with going on to become a high cost utilizer across our analyses, the workgroup also decided to further examine children who entered the system at a young age. The committee determined that an in depth clinical review of a random sample of twenty-five clients from the high cost study group (3+ months above $3,000) who entered the mental health system below age 8 (mean age of entry for the high cost group) could provide additional detail to help explain the differences noted.

The medical records of these clients were thoroughly analyzed focusing on a number of indicators for high utilization such as, but not limited to social, family, clinical, and treatment history in order to understand the reasons for the patterns of utilization (the workgroup

developed a medical record review tool to record all these elements and is included as **Attachment 1**). Results of the chart review are shown in **Table 3**.

Defining the problem:
We did not find evidence of overutilization of services; records we reviewed demonstrated that children received appropriate services given their level of need. What we did identify was the need for early interventions to prevent the need for higher service utilization later on.

Population:
This records review resulted in a decision to define the current study population as children ages 0-5 who have child welfare involvement. Our analysis determined that this cohort may have a gap in services and could experience long term benefits if problems were addressed at earlier ages. Comprehensive rationale for this decision is in item 3a.

Team Brainstorming: "Why is this happening?"
Root cause analysis to identify challenges/barriers

3. a) Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

MHP 3a) Describe MHP issues associated with locally defined problem and patterns. What data supports the MHP's interpretation of the problems and reasons for the problems? Does the data suggest other problems as well? What other evidence within the MHP's system provide additional support to the MHP's interpretation of the data?

While San Diego's findings, thus far, began linking increased severity to the higher average monthly costs for these children, a thorough evaluation of the appropriateness, effectiveness, coordination, and efficiency of service delivery was warranted. In addition, given that younger age at initial entry to the mental health system was significantly associated with going on to become a high cost utilizer across our analyses, the workgroup also decided to further examine children who entered the system at a young age. As noted above the committee determined that an in depth clinical review of a random sample of twenty-five clients from the high cost study group (3+ months above $3,000) who entered the mental health system below age 8 (mean age of entry for the high cost group) could provide additional detail to help explain the differences noted.

Table 3 summarizes findings recorded on the medical record review tools. A complete report of the findings is included as **Attachment 2**.

Table 3 – Medical Records Review Summary of Findings

	Trauma Risk Factors	Totals	%
1	Physical abuse	9	36
2	Emotional abuse	9	36
3	Sexual abuse	5	20
4	Neglect	10	40
5	CWS involvement	23	92
6	Criminal Justice System involvement	0	0
7	Home removal [specify destination]	16	64
8	Multiple placements [specify #]	8	32
9	Other trauma	14	56
Biological Risk Factors			
1	Intrauterine exposure to TOB, ETOH, or drugs	12	48
2	Birth complications	7	28
3	Injury (brain trauma, etc.)	1	4
4	Infection	1	4
5	Toxin exposure (lead, etc.)	0	0
6	Pre-existing conditions	3	12
7	Other	5	20
Psychosocial Risk Factors			
1	Family psychopathology [specify]	18	72
2	Economic hardship [specify]	13	52
3	Substance abuse in house	21	84
4	Substance abuse by client	0	0
5	Incarceration of family member	12	48
6	Caretaker death	1	4
7	Caretaker physical illness	4	16
8	Domestic Violence	17	68
9	Military rotation [specify]	1	4
10	Lack of insurance	2	8
11	Other psychosocial	17	68
Severe Behavioral Risk Factors			
1	Aggression to people	22	88
2	Aggression to animals	4	16
3	Destruction of property	17	68
4	Abnormal sexual behavior	9	36
5	Social impairment	12	48
6	School problems	21	84
7	SI/HI	6	24
8	Other	19	76

92% had CWS involvement

88% had displayed aggressive behavior

84% had problems at school

84% had substance abuse exposure in the home

76% had other behavioral risk factors not specified on the tool that included: self harming behaviors such as head banging and face scratching, trichotillomania, enuresis, encopresis, nightmares, severe tantruming, thumb sucking, attachment issues, and other unsafe and not age appropriate behaviors.

72% had a family psychopathology history

68% witnessed domestic violence

68% had other psychosocial risk factors not specified on the tool such as: parent's separation, frequent moves, sibling separation during home removals, exposure to detrimental health/living conditions.

64% had home removal

56% had other trauma not specified on the tool such as exposure to pornography and sexual activity, extreme violence, homelessness.

48% had intrauterine exposure to tobacco, alcohol and/or drugs

48% had family history of incarcerations

6 children had suicidal ideation and/or homicidal ideation

5 children had documented history of sexual abuse

As is evident, there is a high incidence of CWS involvement among high end users in San Diego County. In addition, the retrospective review of services demonstrated that these clients have a high incidence of trauma, biological and psychosocial risk factors, as well as clinically significant behavioral problems at a young age. It is well known that these problems can have tragic and costly outcomes, including developmental delay, academic difficulties, frequent placement failures, institutionalized care, and delinquency, to name but a few.

San Diego's findings are not surprising; numerous studies have identified that children in foster care have greater needs for mental health treatment than children in the general population. What is disconcerting is the fact that the majority of the predictors or risk factors for high utilization documented in the histories of these children occurred during their first years of development, a time where experiences literally shape the developing brain. Extensive research indicates that the early experiences of life lay the foundation for a child's development now and during the course of his or her life. Unfortunately, signs and symptoms of early social and emotional issues are not always as obvious in babies and very young children as they are in older children. As a result and as commonly seen in the PIP sample, mental health assessment and treatment is delayed until later in life when symptoms are clearly evident and other areas of learning and development are affected.

An examination of the available mental health services for young children in San Diego County was conducted by the workgroup. First, it must be pointed out that significant strides have been made in services for young children in recent years that, unfortunately, came too late for many of the children in the high cost sample: they had aged out of young childhood before the changes were implemented. Also, the involvement of many of the young mental health clients in the child welfare system adds an extra complexity to their situation – they often are experiencing placement and caregiver changes that affect their ability to receive consistent, quality care.

The workgroup identified that while improvements had been made, there was still a lack of sufficient quality services to meet the needs of these young children. Limited evidence-based practices exist for children ages 0-5 and those that do, such as PCIT and the Incredible Years (both of which are offered by San Diego County) typically require consistent caregiver involvement. Children involved in the CWS may be at a disadvantage to access these services, as they may not have a consistent caregiver over time. In addition, these programs were typically not designed to meet the complex needs of children involved in the child welfare system.

In sum, while the initial focus of the PIP was to evaluate the appropriateness of the amount and level of services utilized by the high cost study group, this in-depth medical records review of a sample of clients from the high cost study group indicated that these youth received the right amount and level of services given their age and functioning. The medical records review also identified that 92% of the high cost service users sampled had CWS involvement. Further, the findings from the PIP workgroup indicated that there is a lack of quality services available to meet the needs of children ages 0-5. Therefore, it was decided that it would be beneficial to focus on young clients (defined as ages 0-5) with child welfare involvement who are at-risk for becoming high cost service utilizers.

b) What are barriers/causes that require intervention? Use Table A, and attach as an appendix any charts, graphs, or tables to display the data (preferably in aggregate form). **Do not include PHI**.

Table A – List of Validated Causes/Barriers:

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
1. Poor coordination between CWS and MH staff.	Lack of consistent communication between these two sectors – no formal data sharing in place. Providers may not know that child is receiving services from both sectors, especially when child remains in their own home or with kin.
2. Poor identification of children with need when entering CWS	Most young children entering CWS receive a developmental assessment, but there is no consistent effort to examine their mental health needs. In addition, there may not be a caregiver to report on mental health status when a child initially enters out-of-home care – it may take several weeks to determine what services the child needs.
3. Poor identification of early indicators of risk for development, behavioral, or social delays	Child Welfare is primarily concerned with the safety of children at the time a case opens, and child well-being may take a back seat, at least initially. Sufficient systems are not currently in place to assess all young children entering the CW and MH systems for risk of development, behavioral, and social delays.
4. Poor utilization of outcomes measures by providers (CAMS and CFARS)	Although standardized outcomes measures have been used in the mental health system for several years, they are not consistently being obtained from all caregivers and used by providers for treatment planning. In particular, children in CWS present a problem for these measures, as out-of-home caregivers, such as foster parents and group home providers, may not have sufficient information at intake to complete the assessments, which rely on caregiver report of symptom and behavior history.
5. Limited inclusion of parent/foster parent in treatment	Both parents and foster parents in San Diego County report not feeling that they are involved in treatment sufficiently to be aware of what is going on and to reinforce the therapy work outside of the session. In particular, foster parents report that they are often restricted from obtaining information on services the child has and is receiving, due to CWS policies.
6. Need for better care coordination of high users	Our analyses showed that many of the high cost users initially received disjointed services, had large gaps in service, and typically went on to receive services from more than one provider at the same time. It is not always clear that transition plans have been established at discharge from services, especially when stepping down from higher levels of care.
7. Fewer services available to young children.	Services to children under age 6 are limited in the County and in mental health in general – there are few evidence-based practices for this age group and most are parent-mediated interventions, which may be problematic for a CW involved population.

Formulate the study question

4. State the study question.
This should be a single question in 1-2 sentences which specifically identifies the problem that the interventions are targeted to improve.

Statewide: Will implementing activities such as, but not limited to: increased utilization management, care coordination activities and a focus on the outcomes of interventions lead to enhanced quality, effectiveness and/or efficiency of service delivery to children receiving EPSDT funded mental health services?

MHP: State the local study question which includes the problem as defined by the MHP and the MHP's general approach to addressing the associated causes/barriers.

Will implementing activities such as identification of predictors of high service utilization and the development of appropriate early childhood interventions lead to enhanced quality, effectiveness, and efficiency of service delivery to children, ages 0-5, receiving EPSDT funded mental health services?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.
This PIP is required to include all beneficiaries for whom the study question applies unless there are clear, data-driven reasons for exclusion. Any exclusionary criteria must be carefully considered.

Yes, all beneficiaries are included.

6. Describe the population to be included in the PIP, including the number of beneficiaries.
Exclusionary criteria are discouraged unless the MHP has clinically or programmatically driven reasons, supported by data, to create a study population that is smaller than those who meet the initial dollar threshold. Identify here the total clients who meet the dollar threshold, and for what time frame, as well as the number of clients to be included in the PIP.

All children ages 0-5 in the Child Welfare system will receive an initial screening and assessment. It is expected that approximately 20-30% of these children will receive more in-depth mental health services each year, as indicated by the assessment.

7. Describe how the population is being identified for the collection of data.

All children ages 0-5 open to CWS (there were approximately 800 children who met this criteria in FY08-09) will be screened for inclusion in the PIP.

8. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

No sampling technique was employed.

b)How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

Eligibility is based on a score, tentatively set at 57 or higher on the ASQ:SE, as agreed upon by CMHS and CWS. We expect to serve approximately 20-30% of the screened population.

"How can we try to address the broken elements/barriers?"
Planned interventions

Specify the performance indicators in Table B and the Interventions in Table C.

9. a) Why were these performance indicators selected?

The performance indicators were selected as the quality measure as they address structural & procedural changes that are planned as well as concrete outcomes expected from enhanced services.

b) How do these performance indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes? **Indicators may not focus on the dollar threshold. Indicators should include raw numbers and also be represented as a percentage/rate.**

Table B – List of Performance Indicators, Baselines, and Goals

PERFORMANCE INDICATOR PRIORITY RANKING	DESCRIBE PERFORMANCE INDICATOR	NUMERATOR	DENOMINATOR	BASELINE FOR PERFORMANCE INDICATOR	GOAL	METHODOLOGY FOR DATA COLLECTION	NOTES
1 (old 11)	Outcome measures show improvement in behavioral and/or emotional problems after 26 sessions (KidSTART EPSDT Clinic)	Number of children receiving multiple assessments at KidSTART EPSDT Clinic that showed improvement on the ASQ-SE, CBCL, or CFARS	Total number of children that received multiple assessments at KidSTART EPSDT Clinic	N/A	* 80% of discharged clients will show improvement between intake and discharge on the ASQ-SE, CBCL or ECBI, and CFARS	KidSTART EPSDT Clinic	small n = 6
2 (old 4)	Number of children age 0-5 in CWS receiving county MH services	Number of children, age 0-5, served in both the CWS and CMH Systems **(CWS/MH)**	Total number of children, age 0-5, served in the CWS System **(CWS)**	Percent of CWS clients 0-5 receiving CMH services: FY06/07-15.9% FY07/08-15.2% FY08/09-15.2% FY09/10-16.5%	Previous goal was 5% increase Need to establish new goal based on prevalence	MH/CWS	25-40% of CWS 0-5have behavioral problems, perhaps this is a proxy for the number of CWS youth that should be receiving MHS
3 (old 1)	Developmental screening of children in CWS, age 0-5, through the Developmental Screening and Evaluation Program (DSEP)	Number of children in CWS, age 0-5, that were screened at DSEP	Total number of children, age 0-5, that entered the CWS	% eligible children entering CWS screened at DSEP FY07/08- 96% FY08/09- 97% FY09/10 -99%	FY 10/11 Goal =100% FY 10/11 Achieved = 98%	CWS/DSEP data	98% achieved will be included in the outcome data actual report
4 (old 2)	Number of outpatient services provided to children age 0-5 in CWS (retention)	Number of children in CWS, age 0-5, receiving more than one session among open and closed cases in	Total number of children in CWS, age 0-5 receiving outpatient services, with open and closed cases in FY09/10.	84% FY09/10	Approximately 80%	MH/CWS	

PERFORMANCE INDICATOR PRIORITY RANKING	DESCRIBE PERFORMANCE INDICATOR	NUMERATOR	DENOMINATOR	BASELINE FOR PERFORMANCE INDICATOR	GOAL	METHODOLOGY FOR DATA COLLECTION	NOTES
		FY09/10. N =503	N = 601				
5 (old 3)	% of CWS/MHS clients ages 0-5 receiving an outpatient family service	Number of children in CWS, age 0-5, receiving outpatient MH services with open and closed cases in FY09/10 that had a family service. N = 79	Total number of children in CWS, age 0-5, receiving county outpatient MH services with open and closed cases in FY09/10 N = 658	12% FY09/10	Approximately 20%	MH/CWS	Receiving Outpatient 27% general pop 12% child welfare
6 (old 5)	% of one or more placement changes in children age 0-5 in CWS receiving county MH services	Children age 0-5 in CWS with ≥1 placement change within 12 months of starting MH services. N = 251	Total number of children age 0-5 in CWS receiving services in the CMH system. N = 569	44% of children had one or more placement changes in year following start of MH services in FY 09/10	Establish another baseline to develop trend	MH/CWS	
9 (old 8)	Stability in placements of children with intervention (KidSTART Center and EPSDT Clinic)	Number of children changing placements due to behavior problems or caregiver stress (KidSTART Center and EPSDT Clinic	Total number of children served (KidSTART Center and EPSDT Clinic)	N/A	<20% will change placement due to behavior problems or caregiver stress (4/79)x100=5.1%	KidSTART (Center and EPSDT Clinic)	

*ASQ-SE - a score less than or equal to the cutoff score for clinically significant problems (determined by the questionnaire age interval) at discharge
CBCL - as measured by a 9 point or greater decrease in the total problems raw score
CFARS - discharged clients whose episode lasted 3 weeks or longer, the CFARS score shall be at least one level lower at discharge than at intake in at least one index area
ECBI - how are we measuring improvement?

Remember the difference between *percentage* changed and *percentage points* changed – a very common error in reporting the goal and also in the re-measurement process.

10. Use Table C to summarize interventions. In column 2, describe each intervention. Then, for each intervention, in column 3, identify the barriers/causes each intervention is designed to address. Do not cluster different interventions together. Interventions should be logically connected to barriers/issues identified as causes associated with the problem affecting the study population.

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	Partnership between CWS and CMHS to develop a Screening, Triage, Assessment, Referral and Treatment (KidSTART) Center and EPSDT Clinic co-located within 1 facility that will focus on providing timely intervention when treatment can be most efficient and cost-effective (See **Attachment 3**: Minute Order for San Diego KidSTART Center)	All barrier(s)/causes listed in Table A	FY 2010-11
2	Systematic developmental screening of all children entering foster care through the Developmental Screening and Evaluation Program (DSEP)	#2 in Table A	FY 2010-11
3	Use of developmental screening and assessment instruments which also include caregiver report on social and emotional development for young children such as: ASQ-SE, ECBI	#3 in Table A	FY 2010-11
4	KidSTART EPSDT Clinic shall operate an evidence based practice for children 0-5	#7 in Table A	FY 2010-11
5	Increase involvement of caregivers in services (Note: caregiver participation has been selected as a performance indicator)	#5 in Table A	FY 2010-11
6	Increase access to FSP and TBS programs for children ages 0-5	#6 & 7 in Table A	FY 2010-11
7	MH trainings for providers on service models appropriate for the 0-5 age group	All barrier(s)/causes listed in Table A	FY 2010-11

Apply Interventions: "What do we see?"

Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

The following measures will be used (as appropriately indicated) for all clients unless otherwise noted:

Eyeberg Child Behavior Inventory
Child Functional Assessment Rating Scale
Child Behavior Checklist
UCLA PTSD Reaction Index, parent version
Trauma Symptom Checklist for Young Children
Center for Epidemiologic Studies—Depression Scales (only for Child Parent Psychotherapy (CPP) clients)
Parenting Stress Index (only for CPP and Parent Child Interaction Therapy clients)

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why. Describe how the MHP will collect data for all individuals for whom the study question applies.

Existing Anasazi data will be collected and supplemented with outcome and demographic data from KidSTART, CWS, First 5, and CASRC DES databases. Data on measures list in Q. 11 will be collected at intake, UM cycle, and discharge.

13. Describe the plan for data analysis. Include contingencies for untoward results. What processes will the MHP have in place to ensure that the intervention is applied as intended? How will that be measured?

Descriptive information, placement changes, changes in scores on measures listed in Q. 11.
Contingency plans/Issues inherent to the special population served by this intervention (kids new to foster care) include a "grace periods" of model behavior when children enter new foster homes. This can be addressed with more frequent administration of the ECBI. Additionally, there is the potential problem of caregiver change-- this can be addressed in part with additional questions on measures to identify respondent.

14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

Andrea Hazen, PhD is a Research Scientist at Rady Children's Hospital and licensed clinical psychologist. Dr. Hazen is responsible for data collection, management and analysis of outcomes for children receiving mental health treatment through KidSTART EPSDT Clinic.

Ginger Bial, LCSW is the KidSTART EPSDT Clinic program manager. She provides consultation to KidSTART Clinic Evaluation staff.

Gina Misch, MPH is the KidSTART Center program manager. She is responsible for data collection, management and analysis of outcomes for children receiving triage, assessment, care coordination, and developmental treatments through KidSTART Center.

Lauren Brookman-Frazee, PhD is an Assistant Professor of Psychiatry at UCSD and licensed Clinical Psychologist. She provides consultation to KidSTART Center on program evaluation and outcome measurement.

15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects? What might be next steps in the EPSDT PIP?

Staff at the Child and Adolescent Services Research Center who have been trained in statistical methodology will analyze the data. They will use the numerators and denominators listed in Table B to calculate the performance indicators.

16. Present objective data results for each performance indicator. Use Table D and attach supporting data as tables,charts, or graphs.

Table D - Table of Results for Each Performance Indicator and Each Measurement Period

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
Outcome measures show improvement in behavioral and/or emotional problems (KidSTART EPSDT Clinic)	*N/A*	*N/A*	Goal = 80% of discharged clients show improvement	EBT sessions at KidSTART EPSDT Clinic continuously applied	FY 10/11	(# of children showing improvement/# children receiving multiple assessment)	FY 10/11= 67%
Number of children age 0-5 in CWS receiving county MH services	*FY06/07 – FY09/10*	FY06/07-15.9% FY07/08-15.2% FY08/09-15.2% FY09/10-16.5%	Goal = Maintain 16.5 Percent of CWS clients 0-5 receiving CMH services	Systematic developmental screening of all children entering foster care continuously applied	FY 10/11	(# of children served in both CWS & MH/# children served in CWS)	FY 10/11= 24%
Developmental screening of children in CWS, age 0-5, through the Developmental Screening and Evaluation Program (DSEP)	*FY07/08 – FY09/10*	FY07/08- 96% FY08/09- 97% FY09/10 -99%	Goal = 100% of eligible children entering CWS screened at DSEP	Systematic developmental screening of all children entering foster care continuously applied	FY 10/11	(# of children served in by CWS & screened by DSEP/# children in CWS System)	FY 10/11- 100%

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied			
Number of outpatient services provided to children age 0-5 in CWS (retention)	*FY 09/10*	FY09/10- 84.5%	*Goal*= Maintain 80% of children receiving outpatient services	Partnership between CWS and CMHS continuously applied	FY 10/11	(# of children in CWS receiving > 1 session/ # of children in CWS receiving outpatient services)	FY 10/11= 98.7%
% of CWS/MHS clients ages 0-5 receiving an outpatient family service	*FY 09/10*	FY09/10- 11.5%	*Goal= 20*% of CWS/MHS clients ages 0-5 receiving an outpatient family service	Increase involvement of caregivers in services continuously applied	FY 10/11	(# of children in CWS/MHS receiving family svc/# of children in CWS/MH receiving outpatient services)	FY 10/11= 15.2%
% of one or more placement changes in children age 0-5 in CWS receiving county MH services	FY 09/10	FY09/10- 44%	Goal=10% decrease in one or more placement changes	Increase involvement of caregivers in services continuously applied	FY 10/11	(Children in CWS with ≥1 placement change within 12 months of /children receiving CMH services)	FY 10/11= 40.5%
Stability in placements of children with intervention	*N/A*	*N/A*	Goal=<20% of children will change placement due to behavior problems or caregiver stress	KidSTART Center and EPSDT Clinic co-located within 1 facility	FY 10/11	(# of children changing placements due to behavior or caregiver stress/# of children in out of home placements)	FY 10/11 Center 5% Clinic 11%

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

a. Data cycles clearly identify when measurements occur.

Data cycles are quarterly with most final analysis occurring on an annual basis. Variations to data cycles are identified within measurement results sections.

b. Statistical significance

Due to extended ramp-up and difficulties establishing initial program systems the sample size of beneficiaries with complete admission and discharge outcomes measurement is small. When statistical significance could not be established raw number were used to show actual change.

c. Are there any factors that influence comparability of the initial and repeat measures?

Due to the nature of CWS the caregiver initially completing measures may not be the caregiver that completes outcomes measures after treatment.

d. Are there any factors that threaten the internal or the external validity?

The factors that threaten internal validity are :

1. Clinicians may identify indicators differently, i.e., is a foster parent family may be answered differently between providers .
2. Treatment plans may be to extensive for completion within a highly mobile population.

The factors that threaten external validity:

1. Performance indicators do not encompass all areas of performance.
2. Difference in client need may not be suitable identified with the performance measures available.

18. To what extent was the PIP successful? Describe any follow-up activities and their success.

The following interventions were implemented:

1. Partnership between CWS and CMHS to develop a Screening, Triage, Assessment, Referral and Treatment (KidSTART) Center and EPSDT Clinic co-located within 1 facility.
2. Systematic developmental screening of all children entering foster care through the Developmental Screening and Evaluation Program (DSEP).
3. Use of developmental screening and assessment instruments which also include caregiver report on social and emotional development.

4. KidSTART EPSDT Clinic shall operate an evidence based practice for children 0-5
5. Increased involvement of caregivers in services (Note: caregiver participation has been selected as a performance indicator)
6. Increase access to FSP and TBS programs for children ages 0-5
7. MH trainings for providers on service models appropriate for the 0-5 age group

As a result of the interventions:

67% of children demonstrate improvement in behavioral and social emotional problems.
100% of children have caregiver participation in treatment.
100% of children in CWS were screened for developmental and social emotional delays.

KidSTART is a relatively new program and additional study and program tracking needs to be completed to identify the most impactful outcomes

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?

Methodology used at baseline measurement is the same methodology to be used when the measurement is repeated.

20. Does data analysis demonstrate an improvement in processes or client outcomes?

	Process Outcomes	Numerator	Denominator	Goals	Achieved
1	Evaluation of all eligible children referred to KidSTART EPSDT Clinic, who attended 4 or more sessions, using standardized measures, such as Ages & Stages Eyberg Child Behavior Inventory (ECBI) Questionnaires: Social-Emotional (ASQ:SE) and Child Behavior Checklist (CBCL)	Number of unduplicated children with an eligible referral and who attended 4 or more sessions who were assessed using standardized measures (KidSTART EPSDT Clinic) (n=83)	Total number of unduplicated children with an eligible referral and who attended 4 or more sessions (KidSTART EPSDT Clinic) (n=87)	95%	95%
2	Family participation of children with intervention (KidSTART Center) "family" includes biological, extended, or surrogate family	Number of children with KidSTART Center ICT meetings with caregiver participation (n=18)	Total number of children with KidSTART ICT meetings (with caregiver participation requested by KidSTART Center) (n=20)	95%	90%
3	Family participation of children with intervention (KidSTART EPSDT Clinic) "family" includes biological, extended, or surrogate family	Number of children served through KidSTART EPSDT Clinic with caregiver participation in treatment sessions (at least one time per month) (n=95)	Total number of children served at KidSTART EPSDT Clinic (n=95)	95%	100%

21. Describe the "face validity" – how the improvement appears to be the result of the PIP intervention(s).

KidSTART is a relatively new program and additional study and program tracking needs to be completed before there can be conclusive evidence of true improvement. However, our current implementation of activities such as identification of predictors of high service utilization has lead to increases in the quantity and quality of EPSDT referrals. Also the development of appropriate early childhood interventions has lead to documented improvements in the outcomes of specific clients. Children, ages 0-5, residing in San Diego County receiving EPSDT funded mental health services are receiving enhanced quality, effectiveness, and efficiency in the services being provided.

22. Describe statistical evidence that supports that the improvement is true improvement.

KidSTART is a relatively new program and additional study and program tracking needs to be completed to identify the most impactful outcomes. However, the program appears to have a wide range of positive results.

As a result of the PIP interventions:

1072 children have been screened for developmental delay.

23. Was the improvement sustained over repeated measurements over comparable time periods?

PIP results indicate sustained improvement as clinical and systemwide outcomes continue to improve and increase as the interventions become institutionalized. Additional analysis of program outcomes as KidSTART grows and matures would have be conducted to determine if the initial data indicating that clients with increased caregiver involvement in treatment and better integration of care indicates sustained improvement in the long term utilization of treatment services.

Attachments

Attachment 1: San Diego County EPSDT PIP Medical Record Data Elements Recording Tool

Attachment 2: In-Depth review of 25 Case Files from EPSDT PIP Study Sample – Key Findings Report

Attachment 3: Minute Order for KidSTART Center

SAN DIEGO COUNTY EPSDT PIP MEDICAL RECORD DATA ELEMENTS RECORDING			
Client Name	Sample Case#	**DOB**	
1st Service Date		**MRN**	
1st Service Type		**SSN**	
Primary presenting problem:			

		Yes	Unknown or No Data Documented	Prior to Receiving Services Age		While Receiving Services Age		Notes
Trauma Factors								
1	Physical abuse							
2	Emotional abuse							
3	Sexual abuse							
4	Neglect							
5	CWS involvement							
6	Criminal Justice System involvement [specify type]							
7	Home removal [specify destination]							
8	Multiple placements [specify #]							
9	Other trauma							
Biological Risk Factors								
1	Intrauterine exposure to TOB, ETOH, or drugs							
2	Birth complications							
3	Injury (brain trauma, etc.)							
4	Infection							
5	Toxin exposure (lead, etc.)							
6	Pre-existing conditions (Mental retardation, Chromosomal sd, Develop. d/o)							
7	Other							

Sample Case# Page 2

		Yes	Unknown or No Data Documented	Prior to Receiving Services Age		While Receiving Services Age		Notes
	Psychosocial risk Factors							
1	Family psychopathology [specify]							
2	Economic hardship [specify]							
3	Substance abuse in house							
4	Substance abuse by client							
5	Incarceration of family member							
6	Caretaker death							
7	Caretaker physical illness							
8	Domestic Violence							
9	Military rotation [specify]							
10	Lack of insurance							
11	Other psychosocial							

	Behavioral Risk Factors							
1	Aggression to people							
2	Aggression to animals							
3	Destruction of property							
4	Abnormal sexual behavior							
5	Social impairment							
6	School problems							
7	SI/HI							
8	Other							

Sample Case#							Page 3
		Order of Service Use and length of episodes					
	History of Treatment Settings						
1	IP						
2	OP						
	Crisis Stabilization						
	Crisis Intervention						
	ESU						
3	CM						
4	DT						
5	TBS						
6	Wraparound						
7	Other						

		Yes	No	Notes
1	Client compliance			
2	Caregiver involvement in treatment			
3	Service gap noted [specify]			

Case # Notes Page

In-Depth Review of 25 Case Files from EPSDT PIP Study Sample
Review Period: 2006 to October 2008

In depth MRRs were conducted on 25 children who met the following criteria:

- Were on state list of EPSDT users with $3K+ in expenditure for 3 or more months
- Entered the system before age 8

The service history of the 25 clients included services from 84 different reporting units and resulted in over 100 medical records reviewed

1. Significant Findings:

Table 1 includes predictors or risk factors for high utilization recorded on the medical record review tool. The most significant findings are described to the right.

Table 1

	Trauma Risk Factors	Totals	%
1	Physical abuse	9	36
2	Emotional abuse	9	36
3	Sexual abuse	5	20
4	Neglect	10	40
5	CWS involvement	23	92
6	Criminal Justice System involvement	0	0
7	Home removal [specify destination]	16	64
8	Multiple placements [specify #]	8	32
9	Other trauma	14	56
	Biological Risk Factors		
1	Intrauterine exposure to TOB, ETOH, or drugs	12	48
2	Birth complications	7	28
3	Injury (brain trauma, etc.)	1	4
4	Infection	1	4
5	Toxin exposure (lead, etc.)	0	0
6	Pre-existing conditions	3	12
7	Other	5	20
	Psychosocial Risk Factors		
1	Family psychopathology [specify]	18	72
2	Economic hardship [specify]	13	52
3	Substance abuse in house	21	84
4	Substance abuse by client	0	0
5	Incarceration of family member	12	48
6	Caretaker death	1	4
7	Caretaker physical illness	4	16
8	Domestic Violence	17	68
9	Military rotation [specify]	1	4
10	Lack of insurance	2	8
11	Other psychosocial	17	68
	Severe Behavioral Risk Factors		
1	Aggression to people	22	88
2	Aggression to animals	4	16
3	Destruction of property	17	68
4	Abnormal sexual behavior	9	36
5	Social impairment	12	48
6	School problems	21	84
7	SI/HI	6	24
8	Other	19	76

92% had CWS involvement

88% had displayed aggressive behavior

84% had problems at school

84% had substance abuse exposure in the home

76% had other behavioral risk factors not specified on the tool that included: self harming behaviors such as head banging and face scratching, trichotillomania, enuresis, encopresis, nightmares, severe tantruming, thumb sucking, attachment issues, and other unsafe and not age appropriate behaviors.

72% had a family psychopathology history

68% witnessed domestic violence

68% had other psychosocial risk factors not specified on the tool such as: parent's separation, frequent moves, sibling separation during home removals, exposure to detrimental health/living conditions

64% had home removal

56% had other trauma not specified on the tool such as exposure to pornography and sexual activity, extreme violence, homelessness.

48% had intrauterine exposure to tobacco, alcohol and/or drugs

48% had family history of incarcerations

6 children had suicidal ideation and/or homicidal ideation

5 children had documented history of sexual abuse

As is evident, there is a high incidence of CWS involvement among high end users.

2. Other Findings:

- Significantly younger at service entry: 16 out of 25 were in the 0-5 age group at first episode
- Most of these children had or were in the process of obtaining an IEP and some were classified as ED
- Prescription of multiple psychotropic meds and multiple placements due to behavior problems in the early years was common
- Siblings' involvement with CWS and MHS as well as parent involvement with CWS as minors were recurring findings
- 2 children were registered as "969" youth needing highest level of foster home placement
- 1 child had profound bilateral deafness and was initially placed in foster home with no sign language knowledge

2. Reviewer Observations:

- Records indicate that in many cases, although intensive services were provided, these clients routinely needed higher levels of care.
- Caregivers' frustration with clients' behaviors was frequently identified as a problem, but there was little or no documentation of resources or referrals provided to caregiver.
- Caregivers frequently used emergency response teams as a means of dealing with crisis resulting in frequent client hospitalizations (72hr holds- some of these episodes do not show on INSYST).
- System data shows that only 3 out of the 25 clients used IP; however all three were readmitted within 30 days of discharge.
- Little or no collateral services being provided to the family were documented in records; however administrative collateral services were documented.
- Even though substance abuse, domestic violence, and mental health issues in the family were commonly identified, only 1 case had documentation of services or referrals to address these issues.
- Even though attachment issues were frequently documented, diagnosis of attachment disorder was not made by treating providers.
- Multiple providers involved in treatment, but little or no communication among them was noted on records.
- Client and family history documentation was noted to be frequently poor.
- Age of mother or caregiver was only found on one of the records.
- In many of the cases providers did not routinely request or evaluate prior client's records which appeared to result in duplication of services and/or delay in treatment provision.
- Most of the FFS provider records had inconsistent and incomplete documentation. The quality of records varied greatly, some kept documentation on notebook paper with only 2 sentences for entire assessment.

COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, JANUARY 12, 2010

MINUTE ORDER NO. 2

SUBJECT: COMPETITIVE PROCUREMENT FOR SAN DIEGO KIDSTART CENTER (DISTRICTS: ALL)

OVERVIEW:
The Board of Supervisors has demonstrated a long-term commitment to providing programs designed to specifically meet the needs of abused, neglected or abandoned children placed in foster care.

The Health and Human Services Agency (HHSA), Child Welfare Services (CWS) is mandated to ensure child safety, permanency of living situations and well being. Studies indicate that fifty to seventy-five percent of children entering foster care exhibit developmental delays, behavioral and/or mental health issues. Today's recommendation, if approved by the Board, will address the need to serve children with the most complex issues by implementing a KidSTART Center at a centralized location.

In line with State law, the First 5 Commission of San Diego oversees funds from a tobacco tax initiative approved by voters in 1998. By law, First 5 funding is earmarked for programs that help children ages 0-5 to become "school ready." On September 11, 2009, the First 5 Commission of San Diego approved funding of $5,000,000, over six years, for CWS to develop and implement a KidSTART Center. The KidSTART Center will provide comprehensive assessment, individualized service plans, treatment and coordinated care to promote healthy child development.

As part of this effort, CWS will partner with HHSA Children's Mental Health Services to provide mental health treatment to children at the Center who meet medical necessity for mental health services and are full scope Medi-Cal beneficiaries. If approved, CWS will utilize First 5 funding to leverage additional funds from the State Children's Mental Health Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, beginning in FY 2010-11. The combined total six year amount of First 5 and EPSDT funding for the project will be $9,250,000, through FY 2014-15.

The development of the KidSTART Center supports the Board's vision of providing critical services to the most high-risk children with complex developmental challenges. Today's action requests authority for the Director, Department of Purchasing and Contracting to issue a competitive solicitation for the KidSTART Center, and subject to successful negotiations, award new contracts to provide services for the most vulnerable population of children, ages 0-5.

FISCAL IMPACT:
Fiscal Impact for Child Welfare Services:
Funding for this request is not included in the FY 2009-11 Operational Plan for the Health and Human Services Agency. If approved, this proposal will result in an increase in costs and revenue of $4,250,000 spread over six years, including $500,000 in the current year. The funding source is the First 5 Commission of San Diego. There will be no change in the net General Fund cost and no additional staff years.

Fiscal Impact for Mental Health Services:
Funding for this request is not included in the FY 2009-11 Operational Plan for the Health and Human Services Agency. If approved, this proposal will result in an increase in costs and revenue of $5,000,000 spread over five years, beginning in FY 2010-11. The funding source is State Children's Mental Health EPSDT in the amount of $4,250,000, with $750,000 matching funds from First 5 Commission of San Diego. There will be no change in the net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT:
N/A

RECOMMENDATION:
CHIEF ADMINISTRATIVE OFFICER
1. Establish appropriations of $500,000 in FY 2009-10 in the Health and Human Services Agency, Child Welfare Services for the KidSTART Center based on unanticipated revenue from the First 5 Commission of San Diego.**(4 VOTES)**

2. In accordance with Section 401 et. seq. of the County Administrative Code, authorize the Director, Department of Purchasing and Contracting to issue a competitive solicitation for assessment and treatment for developmental delay services to children, ages 0-5, for the KidSTART Center, and upon successful negotiations and determination of a fair and reasonable price, award a contract for assessment and treatment of developmental delay services to the identified population for a term of one year and two months, with four option years, and up to an additional six months if needed, and to amend the contracts as needed to reflect changes to services and funding, subject to funding availability and approval of the Director, Health and Human Services Agency.

3. In accordance with Section 401 et. seq. of the County Administrative Code, authorize the Director, Department of Purchasing and Contracting to issue a competitive solicitation for mental health treatment services to children 0-5, in conjunction with the KidSTART Center, and upon successful negotiations and determination of a fair and reasonable price, award a contract for mental health treatment services to the identified population for a term of one year, with four option years, and up to an additional six months if needed, and to amend the contracts as needed to reflect changes to services and funding, subject to approval of the Director, Health and Human Services Agency.

ACTION:
ON MOTION of Supervisor Cox, seconded by Supervisor Roberts, the Board took action as recommended, on Consent.

AYES: Cox, Jacob, Slater-Price, Roberts, Horn

- - -

State of California)
County of San Diego) §

I hereby certify that the foregoing is a full, true and correct copy of the Original entered in the Minutes of the Board of Supervisors.

THOMAS J. PASTUSZKA
Clerk of the Board of Supervisors

By_____
Marvice E. Mazyck, Deputy

California EQRO
560 J Street, Suite 390
Sacramento, CA 95814

CAEQRO PIP Outline via Road Map

MHP: San Diego
Date PIP Began: April 2010
Title of PIP: Mental Illness Stigma Reduction Media Campaign
Clinical or Non-Clinical: Non-Clinical

Assemble multi-functional team

1. Describe the stakeholders who are involved in developing and implementing this PIP.
MHP Level Committee: List local PIP committee members including their position and affiliation.

The County of San Diego utilized input from a broad spectrum of stakeholders in the development and implementation of the Prevention and Early Intervention Plan which includes the Stigma and Discrimination Reduction Media Campaign. Input was gathered from community forums, focus groups, and Mental Health Councils, etc. to identify key priority areas for this outreach and education media campaign program. **The following groups of people participated in developing and/or implementing the County's Stigma and Discrimination Campaign.**

- HEALTH STRATEGY – PREVENTION IMPLEMENTATION TEAM
- HEALTH PROMOTIONS COMMITTEE
- MENTAL HEALTH SERVICES ACT PLANNING COMMITTEE
- HHSA BEHAVIORAL HEALTH DIVISION
- METROPOLITAN GROUP
- COOK & SCHMID
- AdEASE

The following people participated in developing and/or implementing the County's Mental Illness Stigma Reduction Media Campaign PIP.

PIP Development and Implementation Team		
Name	**Affiliation**	**Position**
Kathy Anderson	SD County Behavioral Health Services (BHS)	Principal Analyst Quality Improvement
Marissa Crane	UCSD Health Services Research Center	Program Evaluator
Rick Heller	UCSD Health Services Research Center	Program Evaluator
Samantha Lea	QI, Performance Outcomes Group	Project Analyst
Candace Milow	SD County Behavioral Health Services (BHS)	Director, Quality Improvement Unit
Donna Peterson	SD County Behavioral Health Services (BHS)	Admin Analyst II, MHSA
Andrew Sarkin	UCSD Health Services Research Center	Research Scientist, Center Manager
Marisa Sklar	UCSD Health Services Research Center	Program Evaluator
Karen Ventimiglia	SD County Behavioral Health Services (BHS)	Administrative Analyst III, MHSA Coordinator

"Is there really a problem?"

2. Define the problem by describing the data reviewed and relevant benchmarks. Explain why this is a problem priority for the MHP, how it is within the MHP's scope of influence, and what specific consumer population it affects.
MHP:

With the advent of MHSA, funding became available to expand community and support mental health services and create new ones to reach out to un-served and underserved population in the County. Efforts to engage these populations through traditional channels of outreach by programs had not been as successful as originally anticipated. Penetration rates did not show much improvement over time, nor did Annual Databook statistics on the types of clients served. This is a significant problem for the MHP, since more than 22% of San Diego's population was born in another country and 42% of children have one or more foreign born parents*. In depth examination of data about racial, ethnic, age and gender disparities in formulating the State required Cultural Competence Plan 2010 revealed populations with very low engagement and/or low retention.

According to Dr. David Satcher, U.S. Surgeon General, one in five Americans struggles with a mental illness in any given year, fewer than half receive the right kind of treatment. Those who fail to get care are held back by enduring stigma, a fragmented system of mental health care delivery, and financial strains.

> "Stigmatization of people with mental disorders is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads the (public) to avoid people with mental disorders. It reduces access to

resources and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care. Stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society." (U.S. Surgeon General Dr. David Satcher)[1]

On the Federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently facilitated a three-year Elimination of Barriers Initiative in recognition of the major impact that stigma and discrimination has on those living with mental illness. The initiative gave consumers an opportunity to voice their concerns and needs related to these areas, and approaches to address discrimination and stigma were tested in eight states across the country.

On the state level, the California Strategic Plan on Reducing Mental Health Stigma and Discrimination provides a blueprint for action at the local and state levels, as well as an informational resource for government, community-based organizations, consumer and family groups, and others. It serves as a tool for individuals, both within and outside of the mental health field, who are dedicated to ensuring the complete social inclusion of people of all ages living with mental health challenges.

In San Diego, input from the community and stakeholders reinforced the concern that stigma and discrimination were important causative factors contributing to people's reluctance to seek services for themselves or their family/friends. San Diego County used stakeholder input to develop more than 30 Prevention and Early Intervention (PEI) programs to improve outcomes for several specific populations. Funds were provided to increase screening and implement early interventions for mental health problems in alcohol and drug treatment programs, primary care practices, elder support services, and services provided to ethnic minorities. The largest program implemented using PEI funds is an ongoing media campaign. The Mental Health System's stakeholders decided that the SDCBHS was finally in a position to be able to conduct a vigorous multi-media campaign to try to educate the public and increase their awareness about mental health issues, the existence of a path to recovery from mental illness, and sources of community assistance for mental health problems. There was no other volunteer or governmental entity in the County with the financial ability and will to do the level of education and outreach required to be able to make a difference.

*"The State of Metropolitan America", Brookings Institution, as cited by Katie Orr, KPBS, May 10, 2010.

Team Brainstorming: "Why is this happening?"
Root cause analysis to identify challenges/barriers

3. a) Describe the data and other information gathered and analyzed to understand the barriers/causes of the problem that affects the mental health status, functional status, or satisfaction. How did you use the data and information to understand the problem?

As described above, stigma and discrimination often stand in the way of opportunities (e.g. jobs, housing, and treatment) for individuals with mental illness. Various research sources and data reports were studied to determine challenges and barriers to the problems of stigma and discrimination. These included:

- Developing a Stigma Reduction Initiative (SAMHSA, 2006)
- What a Difference a Friend Makes (SAMHSA, 2006)
- Youth Champions for Home (United Advocates for Children and Families, 2007)
- California Strategic Plan on Suicide Prevention (California DMH, 2008)
- Progress Toward Reducing Disparities: A Report for San Diego County Mental Health – A Five-Year Comparison FY2000-01 to FY2006-07
- Telephone survey on behalf of the County HHSA to determine San Diegans' awareness and understanding of mental illness
- In addition, calls to the MHP Access and Crisis Line and visits to the website were gathered and analyzed

b) What are barriers/causes that require intervention?

Table A – List of Validated Causes/Barriers:

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
The San Diego public is lacking awareness about the causes and symptoms of mental illness	The Mental Health Literacy scale was developed using questions from the Strata Research telephone survey to assess general beliefs about mental illness and treatment. At baseline, questions from the survey indicated: • 68.3% of respondents believed that mental illness is caused by stress • 43.0% of respondents mistook the symptoms for depression or schizophrenia as the "normal ups and downs of life" • 59.1% of respondents attributed the symptoms of depression or schizophrenia as a physical illness • 23.0% of respondents could not recognize the symptoms of schizophrenia, and 6.3% could not recognize the symptoms of depression
The San Diego public does not know how to recognize symptoms of mental illness, or warning signs of suicide	Another scale in the Strata survey is the Mental Health Knowledge & Access scale, which measures knowledge of and willingness to use community resources for mental illness. At Baseline, items within this scale indicate that: • 41.7% of respondents did not know how to recognize the warning signs of suicide in other people • 27.2% of respondents did not know how to recognize emotional or behavioral problems in children
The San Diego public is not aware of resources available to people with mental illness	Additional items from the Mental Health Knowledge & Access scale indicated that at Baseline: • 39.7% of respondents were not aware of community resources for mental health problems that are easy to access and understand • 19.2% of respondents did not know where to get help if they saw someone in their family showing warning signs of suicide Additionally, at Baseline, only 11.6% of respondents reported that they had received treatment within the past 12 months or were currently receiving treatment. 14.6% of respondents reported that they had received treatment more than a year prior.
Because of a lack of	The Lack of Social Distancing scale was developed to demonstrate a respondent's willingness to be socially connected

Describe Cause/Barrier	Briefly describe data examined to validate the barrier
knowledge about mental illness, people have discriminatory behaviors toward persons with mental illness	to people with mental illness. At baseline, items on this scale indicated that: • 32.7% of respondents would feel nervous or uncomfortable being around a person with mental illness • 33.1% would NOT be willing to work closely with a person with mental illness • 62.7% would NOT be willing to have a person with mental illness marry into their family • 48.1% believe that a person with mental illness is more likely than others to be dangerous
Public stigma augments self stigma and interferes with persons getting help	The final scale within the Strata phone survey data is Mental Health Openness, which measures openness to disclosing mental health problems. Items within this scale indicated that: • 44.5% of respondents overall would be afraid to tell others about their situation if they had a mental illness • 46.7% of respondents thought that a person would lose friends if others knew about his or her mental illness • 10.8% of respondents agreed that a person would be better off keeping his or her mental health problems a secret

Formulate the study question

4. State the study question.

This should be a single question in 1-2 sentences which specifically identifies the problem that the interventions are targeted to improve.

Is a comprehensive, multi-media education campaign an effective method to improve public awareness and knowledge about mental illness and an effective vehicle to help decrease stigma and discrimination about persons with mental illness?

5. Does this PIP include all beneficiaries for whom the study question applies? If not, please explain.

Media-based outreach and education - Outreach and education efforts will be focused on transition age youth (ages 18-24), adults and older adults, as well as families of children with mental health problems. These activities will expand upon the state DMH plans on stigma reduction and suicide prevention. In addition, because many persons consult with their family doctor first about mental health problems, the campaign will also outreach to physicians to be sure that they have information about mental health resources in San Diego.

Stigma Reduction – A variety of projects have been implemented around the country dealing with the issue of stigma and discrimination. Strategies from these projects will be modified to address the unique characteristics of San Diego County and specific target populations. The selected strategies were integrated in the media campaign targeting stigma reduction include:

- Engaged the advertising/media firms AdEase, Metropolitan Group, and Cook & Schmid to develop a community education media plan
- Conducted general and targeted advertising campaigns in English, Spanish, and the threshold languages
- Established websites to focus on the specific needs of Transition Age Youth (TAY), adults, Hispanics, and physicians
- Created printed materials to include flyers, posters, brochures, fact sheets, cards, calendars, etc.
- Held a news conference kicking off the campaign
- Ran TV/radio/print ads (in threshold languages, as well as English) on stigma reduction
- Designed and distributed targeted materials to groups determined to be unserved and underserved populations as identified by the MHSA, local data, and community input.

6. Describe the population to be included in the PIP, including the number of beneficiaries.

The target populations for this PIP are wide-ranging, including:

- County-wide residents (approximately 3 million*)
- Youth and adults in County (approximately 2,340,000*)
- Individuals with mental illness
- Families, friends, and caregivers of individuals with mental illness
- General public

*(based on 2010 census data)

The demographic distribution of residents of San Diego County who participated in the media campaign survey is described below:

- Gender: 44% male and 56% female
- Ethnicity: Caucasian 59%; Hispanic 29%; Asian 3%; African/African-American 2%; Native American 1%; Other <1%
- Age: 18-24 11%; 25-34 16%; 35-44 16%; 45-54 23%; 55-64 18%; 66-74 10%; 75+ 6%

7. Describe how the population is being identified for the collection of data.

Data was collected from 602 San Diego residents through a 15-minute Random Digit Dialed (RDD) telephone interview. Telephone numbers dialed were a mix of landline and mobile phones. A random selection of survey participants was determined so that a representative mix of demographics was achieved to mirror the population in San Diego County. In total, 602 respondents completed the poll, providing a +/-4.0% Margin of Error.

Strata Research Inc. was hired to collect data on the campaign over time and UCSD's Health Services Research Center is completing an evaluation of the results.

8. a) If a sampling technique was used, how did the MHP ensure that the sample was selected without bias?

A random sample of respondents was selected so that a representative mix of demographics was achieved to mirror the population in San Diego County. Towards the end of data collection, interviewers terminated the survey after obtaining demographics information from a participant if their demographic background was already overrepresented in the sample. This way, participants were still randomly recruited, and the proportions were adjusted to maintain a representative sample. In total, 602 respondents completed the poll, providing a +/-4.0% Margin of Error.

The campaign reached out via multiple sources (see list below) ensuring that the entire targeted population would have the opportunity to be exposed to campaign materials.

- Scheduled morning shows, newscasts, special programming
  - KPBS "These Days"
  - CW6 Morning News
  - KUSI 9/51
  - Despierta San Diego (Univision)
  - KOGO
- Network of Care Website
- Micro-sites for Transitional Age Youth, Hispanic community, and physicians
  - Mailed Personalized URL direct mailer to 9,000 physicians purchased from the SD County Medical Society and to 1,625 San Diego County Nurse Practitioners and Physician Assistants that subscribe to the Clinical Advisor
- Media
  - Cable (363 spots on Cox Media Interconnect)
  - Radio (380 spots on various network stations and 529 spots on Hispanic Radio FM stations)
  - Local TV (306 spots)
  - All committed to match each paid spot with unpaid
- Digital Media
  - SignOnSanDiego
  - Yahoo
  - Google
  - Facebook

- Tremor Media
- Additional Media
  - Outdoor (bus panels on busses throughout the County, posters/shelters)
  - Cinema (9 San Diego theaters on 142 screens)
  - Print (including SDSU Daily Aztec; UCSD Guardian; Military Press; Asian Journal; El Latino; and San Diego Family Magazine; San Diego Reader; and San Diego Village Voice)
  - Community Bulletins (8,000 total in English and Spanish)
  - Culturally selected Community Outreach (brochures targeted towards older adults, Filipino, Vietnamese and TAY)
  - Fotonovela (130,000 copies distributed throughout San Diego County)

Inherent in any statistical inference is random error associated with the findings. For a sample size of 602, the random error of any percentage reported is +/-4.0% at the 95% confidence level. This means that the method used to create confidence intervals is successful 95% of the time. That is, if the study were conducted 100 times, each time with a new sample, 95 of those 100 studies would cover the true value that we are estimating using the sample.

b) How many beneficiaries are in the sample? Is the sample size large enough to render a fair interpretation?

In addition to conducting a baseline survey on mental health stigma, Strata conducted a follow up study in March 2011, six months after the launch of the media campaign. After hearing descriptions of each of the television ads, 59% of participants remembered seeing at least one of the television ads. The sample was sufficiently large, and representative of the population of San Diego County, so we can extrapolate that approximately the same proportion of San Diego residents had seen the television spots over the first six months of the campaign. However, this was only one component of the campaign, and it is likely that a greater percentage of residents had been exposed to other components, such as the outdoor signage, or brochures. Over the subsequent years of the campaign, Strata will continue to conduct annual surveys to determine the penetration of the campaign into the community.

"How can we try to address the broken elements/barriers?"
Planned interventions

Specify the performance indicators in Table B and the Interventions in Table C.

9. a) Why were these performance indicators selected?

The Strata phone survey contained several sections designed to determine attitudes and behaviors towards people with mental health problems. HSRC conducted factor analysis using the baseline data to create appropriate scales using these items. Analysis revealed four scales that relate to different aspects of mental health literacy and stigma. These concepts measured by the scales correspond to the key barriers determined by stakeholders that prevent San Diego residents from receiving adequate treatment. They also reflect the content of the media campaign. Scales were used because they accurately capture current sentiments about mental illness, and monitor changes over time.

The Mental Health Literacy and Mental Health Knowledge & Access scales reflect participants' knowledge about mental illness, causes, signs and symptoms, and treatment resources. The Mental Health Openness and Lack of Social Distancing scales reflect participants' stigma towards people with mental illness, willingness to associate and help others suffering from mental illness, and willingness to personally seek treatment.

b) How do these performance indicators measure changes in mental health status, functional status, beneficiary satisfaction, or process of care with strong associations for improved outcomes?

These performance indicators represent many of the initial barriers that prevent people from seeking treatment for mental illness. General knowledge about symptoms and treatment options for mental illnesses was lacking at the baseline measurement. Approximately 40% of participants were not aware of mental health resources in their community, and over 40% did not know how to recognize the warning signs for suicide in others. Additionally, many respondents held false beliefs about the origin of mental illness, and the efficacy of treatment.

Through the media campaign, viewers were taught about mental illnesses, and given a phone number and website to find information about seeking treatment for themselves or others. People cannot recover from mental illness until they know that help is available, and they feel comfortable seeking treatment. Increases in the four indicators below would demonstrate increased knowledge within the community and a more accepting environment for people with mental health problems to reach out to others, accept help, or seek treatment.

At the baseline, 11.6% of participants reported that they were either currently receiving treatment, or had received treatment in the past year. After the first six months of the media campaign, that increased to 14.0% of participants. This could be attributed to more people receiving care, or people feeling more comfortable discussing their treatment. This increase corresponds to the increase in indicator number 3 in Table B below, and could be attributable to the media campaign. Open discussions about mental illness and recovery similar to those in campaign materials set a less stigmatizing, more supportive backdrop for others to seek treatment.

Remember the difference between *percentage* changed and *percentage points* changed – a very common error in reporting the goal and also in the re-measurement process.

Table B – List of Performance Indicators, Baselines, and Goals (From Strata Survey)

#	Describe Performance Indicator	Numerator	Denominator	Baseline for performance indicator	Goal
1	Mental Health Literacy Scale	Number of participants with a mean scale score ≥3	Total number of respondents	Baseline Strata Survey conducted in September 2010	10% improvement over first 6 months of campaign
2	Lack of Social Distancing Scale	Number of participants with a mean scale score ≥3	Total number of respondents	Baseline Strata Survey conducted in September 2010	5% improvement over first 6 months of campaign
3	Mental health Openness Scale	Number of participants with a mean scale score ≥3	Total number of respondents	Baseline Strata Survey conducted in September 2010	3% improvement over first 6 months of campaign
4	Mental Health Knowledge & Access Scale	Number of participants with a mean scale score ≥3	Total number of respondents	Baseline Strata Survey conducted in September 2010	5% improvement over first 6 months of campaign

* See Appendix A for Strata Survey Baseline Data

10. Use Table C to summarize interventions. In column 2, describe each intervention. Then, for each intervention, in column 3, identify the barriers/causes each intervention is designed to address. Do not cluster different interventions together.

Table C - Interventions

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
1	AdEase Up2SD campaign, including television and radio spots, billboards, and other outdoor signage	This campaign has specific components that are targeted to address each of the barriers listed in Table A.	September 2010 – Current
2	Up2SD.org website with information and resources for residents and medical professionals	This component of the campaigns focuses on providing treatment options and resources to increase knowledge about mental illnesses, and addresses each of the barriers listed in Table A.	September 2010 - Current
3	Metropolitan Group Fotonovela, “Salir Adelante”	This campaign has specific components that are targeted to address each of the barriers listed in Table A.	Distributed November 2010, March 2011
4	Cook & Schmid Housing Matters television spots	This campaign has specific components that are targeted to address each of the barriers listed in Table	November 2010 - Current

Number of Intervention	List each specific intervention	Barrier(s)/causes each specific intervention is designed to target	Dates Applied
		A.	
5	HousingMattersSD.org websites with information and resources for residents about supportive housing and mental illness	This component of the campaigns focuses on providing resources to increase knowledge about homelessness and mental illnesses. It primarily addresses barriers 1, 2, 5, and 6 listed in Table A.	September 2010 - Current

Apply Interventions: "What do we see?"
Data analysis: apply intervention, measure, interpret

11. Describe the data to be collected.

The Up2SD media campaign created by AdEase encourages San Diegans to "Speak up" and get help or "Listen up" and offer support. This campaign primarily addresses mental health stigma and discrimination.

The table below lists the data to be collected on the survey to respondents and sample questions for each item.

Measure	Opinion Soliciting Statements
Message Recall – measures recall of messages with prompting	• Depression is not a normal part of aging • Mental health challenges affect 1 in 4 adults • Mental health is part of your overall health • Just one friend reaching out can make a difference • Every day people recover from mental illness
Social Distancing (Stigma) – assesses participants' comfort being close to someone with mental health problems	• I would be willing to have him/her as a neighbor • I would be willing to work with him/her on a job • I would be willing to have him/her marry a family member • Being around him/her would make me feel nervous or uncomfortable
Mental Health Openness – assesses participants' willingness to disclose mental health problems	• I would be afraid to tell people about my situation if I had mental health problems • He/She would lose friends if people knew about his/her mental health problems • His/Her family would be better off keeping his/her problem a secret
Mental Health Literacy – assesses the participants' knowledge about the causes of and treatment for mental health problems	• It is likely that he/she is experiencing mental illness/schizophrenia/depression • I believe that mental health issues are common

	• It is likely that his/her situation will improve with treatment • I believe that suicide is preventable • Mental health is as important as physical health
Mental Health Knowledge & Access – assesses participants' knowledge about available mental health resources, and when they should be utilized	• My community has resources for mental health problems that are easy to access and understand • I know how to recognize the warning signs • I know where to get help if I saw someone in my family showing warning signs of suicide • I know where to seek help in my community for emotional and behavioral problems

12. Describe method of the data collection and the sources of the data to be collected. Did you use existing data from your Information System? If not, please explain why.

Strata Research, Inc. was contracted to conduct data collection on mental health stigma, and the market penetration of the media campaign. All data was gathered through Random Digit Dialed phone interviews to obtain a representative sample of San Diego County. Although several surveys have been administered relating to mental health stigma and treatment history, they related to participants in current County programs, and for an intervention as broad as the media campaign we required a representative sample of all San Diego residents. Additionally, no previous measures have included items specific to media exposure.

13. Describe the plan for data analysis. Include contingencies for untoward results.

The study is being conducted in two phases: Phase I: Awareness; and Phase II: Resource Utilization.

Phase I is broken into stages as follows:

Wave I was conducted in April 2010 to measure:

- Baseline awareness of mental illness, and perceptions towards people with mental health problems
- Differences in awareness and perception between individuals based on demographic background or experience (gender, age, race, number of children under 18, residence, employment and military status, and an overall self-assessment of mental and physical health)
- Awareness and perception of mental health (e.g. suicide) risk factors

Wave II was conducted in March 2011 to measure changes in awareness and perceptions and to track campaign awareness.

Wave III will be conducted in March 2012 to continue to track changing mental health knowledge, and attitudes towards people with mental illnesses.

Phase II includes the analysis and results of the project.

As this campaign is ongoing, reports are currently intended for learning purposes. Results from Wave II were used to guide the direction of future media spots and advertising materials in order to best reach and influence the targeted population. For example, in the table below, it is clear that participants in the survey found certain spots to be more educational or influential on their behaviors than others. AdEase adjusted ad placement to show the most effective ads to the largest population, while phasing out the less effective ads. Additionally, new ads are developed each year that incorporate information that was not conveyed in previous ads (ex. Warning signs for suicide).

	Coach John	Bill & Doug	Older Adults	Tyler
Listening to this ad…	**% Agree or Strongly Agree**			
Helped you recognize symptoms of mental health problems[2]	48.0%	64.5%	75.2%	76.1%
Helped you recognize warning signs of suicide[2]	29.7%	43.8%	37.2%	42.1%
Gave you information on how to get help[2]	75.2%	79.3%	83.5%	83.5%
How did this ad affect your likelihood to…	**% Very much or Somewhat**			
Be as supportive as possible to someone experiencing MI[1]	76.7%	74.1%	83.5%	59.5%
Make an effort to find out more about MI[2]	59.1%	63.8%	65.8%	69.3%
Treat others who have MI with respect[2]	79.3%	73.7%	84.2%	86.1%
Feel comfortable talking to a friend or family member about their MI[2]	67.2%	73.0%	76.3%	78.1%

Wave II, some significant results from the analyzed data include:

- Respondents were significantly more likely to report receiving treatment at Wave II than they were at Wave I.
- In Wave II, mean scores on the Mental Health Openness scale was significantly higher than at Wave I, indicating that participants are more open to discussing mental illness and seeking treatment.
- Call volume to Access and Crisis lines were greater 30 and 60 minutes following a televised Up2SD spot than they were 30 and 60 minutes prior to the commercial, respectively.
- In direct exposure studies, a large majority of respondents felt that they increased their mental health knowledge and positively changed their attitudes towards people with mental illness (see table above).

In Waves I and II participants were asked for their recollections on the campaign including TV and radio ads, billboards, and posters. Mid-year awareness study findings are below:

Campaign Exposure

Over half (54%) of the County's residents had recently heard or seen ads or messages pertaining to mental health challenges and mental illness. When prompted with a description of specific Up2SD spots, 59% of participants remembered having previously seen it.

- 72%* indicated seeing messages on TV (compared with 32% in the baseline study).
- 25%* indicated seeing messages in a newspaper or magazine (compared with 16% in the baseline study).
- 18%* indicated hearing messages on the radio (compared with 9% in the baseline study).
- 14%* indicated seeing billboards (compared with 6% in the baseline study).
- 13%* indicated seeing messages online (compared with 4% in the baseline study).
- 12%* indicated seeing or reading a newsletter or brochure (compared with 6% in the baseline study).
- 8%* indicated seeing messages on a bus (compared with 2% in the baseline study).
- 5%* indicated seeing messages in a theater (compared with 1% in the baseline study).

*indicates significant difference to baseline study

Knowledge, Attitude and Behavior Change

San Diegans who saw the campaign ads:

- Scored significantly higher on the Lack of Social Distancing scale (t=2.072, *p*=.039), indicating increased willingness to include a person with mental illness in their social environment.
- Scored significantly higher on the Mental Health Knowledge & Access scale (t=2.365, *p*=.018) indicating increased knowledge of the symptoms of mental illnesses and appropriate resources.
- Were more comfortable talking to a friend or family member about their mental health (36% vs. 31%, χ^2=2.946, *p*=.086).
- Were more likely to know of community mental health resources (65% vs. 56%, χ^2=3.756, *p*=.053).
- Were more likely to know how to recognize warning signs for suicide (62% vs. 54%, χ^2=3.415, *p*=.065).
- Were more likely to know where to get help for someone showing warning signs of suicide (81% vs. 74%, χ^2=3.624, *p*=.057).
- Compared with Wave I, in Wave II a significantly larger proportion of respondents reported that if they were suffering from a mental illness, they would seek help from: family or friends (66% vs. 52%), a medical doctor (81% vs. 70%), a counselor or psychologist (80% vs. 69%), a crisis line (52% vs. 37%), a spiritual leader (42% vs. 32%), a website (37% vs. 28%), or an employer (2% vs. 0%).

14. Identify the staff that will be collecting data as well as their qualifications, including contractual, temporary, or consultative personnel.

San Diego County worked with AdEase and UCSD's Health Services Research Center (HSRC) to develop the mental health survey, and design a data collection plan. AdEase is an advertising, marketing and public relations agency located in San Diego with experience in developing large-scale public service campaigns. Strata Research Inc. was hired by AdEase to conduct the phone interviews according to the procedure agreed upon by San Diego County, AdEase, and HSRC. HSRC is a non-profit research organization within UC San Diego's School of Medicine, Department of Family and Preventive Medicine. Formerly known as the Health Outcomes Assessment Program, HSRC has been providing a comprehensive variety of research services since 1991 to academia, corporations, and individuals worldwide. HSRC's mission is to support research focused on understanding how clinical and treatment services affect health outcomes. The center was contracted to guide the campaign and analyze resulting data due to their expertise in health outcomes, program evaluation, quality of life measurement, mental health, and medical research informatics. Lead research staff on this project included:

Andrew Sarkin, Ph.D. is a Clinical Psychologist and Project Scientist at UC San Diego and Center Manager of HSRC since 2001. He has served as a project manager of HSRC's contract to provide Data Analysis and Performance Monitoring to San Diego County Behavioral Health Services since 2007. He also oversees the evaluation of the San Diego MHSA Prevention and Early Intervention (PEI) and MHSA Innovations efforts that consist of dozens of programs. He was a key contributor in the development of the evaluation plan and survey instruments being used to assess the impact of the PEI media campaigns and other interventions in San Diego and has managed several other large projects during his ten years with HSRC.

Marisa Sklar, M.S. was primarily involved in the planning stages of the media campaign, and analysis of the baseline data. Marisa holds a Master's degree in Program Evaluation from San Diego State University. She specializes in the dissemination of evaluation findings.

Marissa Crane, M.S. was primarily involved in data analysis for the media campaign, including tracking program progress, and suggesting areas for program improvement. Marissa holds a Master's degree in Program Evaluation from San Diego State University. Marissa focuses on the ongoing evaluation of the San Diego County Mental Health Services Prevention and Early Intervention projects, including all aspects of data analysis, reporting, and liaison with community groups. In reporting on program development, she regularly solicits stakeholder feedback through groups such as the Suicide Prevention Council.

15. Describe the data analysis process. Did it occur as planned? Did results trigger modifications to the project or its interventions? Did analysis trigger other QI projects?

In April 2010, Strata conducted Wave I of the study to determine San Diegans' current basis of awareness and understanding of mental illness that will be used to gauge the effectiveness of the multimedia education and information campaign. The study aimed to measure:

- San Diegans' baseline awareness and perception of mental illness, including stigma, suicide risk factors, signs and symptoms, as well as information and resources available to assist individuals experiencing these problems.
- The differences in awareness and perceptions among key factors such as experience with mental illness, gender, age, and ethnicity.

In March 2011, Wave II was conducted to assess changes in awareness and perception, attitudes, and treatment history. Participants were also asked about their exposure to specific campaign materials. Additionally, HSRC conducted a smaller scale survey, also using Random Digit Dialing that included a direct exposure component where participants listened to the campaign media spots and rated them on various factors. Results from this analysis can be found in the table on page 13.

For Wave I of the study, HSRC primarily focused the analysis on examining mental health literacy and attitudes, and comparing scores for various target groups. Results showed the expected deficiencies in knowledge about mental health and treatment resources. Prior to implementing the survey, stakeholders had indicated several populations that would require targeted campaigns, such as older adults, transition age youth, and Hispanics. As anticipated, these groups tended to be more stigmatizing, and had lower knowledge of mental illnesses and resources.

Data analysis for Wave II also went as planned. Four scales were developed using the knowledge and attitude items to more accurately capture changes over time. These were Mental Health Literacy, Mental Health Knowledge & Access, Mental Health Openness, and Lack of Social Distancing. Analyses included t-tests and χ^2 tests, which were used to compare responses from Wave I to Wave II. Additional analysis was conducted to examine changes in treatment history, and media exposure.

Data from the HSRC direct exposure study was used to analyze the effects of each media spot. The results from these analyses can be found in the table on page 13. Participants were able to relate to some of the spots better than others, and felt that several conveyed their message more effectively. Additional analyses confirmed that the spots that were considered more effective were also remembered more often when controlling for the overall exposure of each spot. Results were used to direct the content and placement of campaign materials to meet the continuing needs of the community. AdEase adjusted ad placement to show the most effective ads to the largest population, while phasing out the less effective ads. The most memorable spot was also selected to be broadcast in movie theaters throughout San Diego County. Additionally, new ads are developed each year that incorporate information that was not conveyed in previous ads (ex. Warning signs for suicide).

The informative direct exposure findings led QI to implement an additional direct exposure survey to determine the perceived impact of the fotonovela, *Salir Adelante*, developed by Metropolitan Group. In order to show participants the fotonovela, an online survey was created and advertised through Spanish language newspapers, Facebook, Craig's List, and local

universities. A majority of the items on this survey resembled the previous media survey in order to generate comparable data, however several questions were added, and others were modified to shift the focus to the fotonovela.

16. Present objective data results for each performance indicator. Use Table D and attach supporting data as tables, charts, or graphs.

Table D - Table of Results for Each Performance Indicator and Each Measurement Period (From Strata Survey)

Describe performance indicator	Date of baseline measurement	Baseline measurement (numerator/ denominator)	Goal for % improvement	Intervention applied & dates applied	Date of re-measurement	Re-measurement Results (numerator/ denominator)	% improvement achieved
THIS IS THE BASELINE INFORMATION FROM TABLES A, B, AND C USED HERE FOR COMPARISON AGAINST RESULTS							
Mental Health Literacy Scale	April 2010	(147/556) 26.4%	Increase by 10%	Media Campaign, September 2010-Current	March 2011	(155/569) 27.2%	(0.8/26.4%) 3.0%
Lack of Social Distancing Scale	April 2010	(315/594) 53.0%	Increase by 5%	Media Campaign, September 2010-Current	March 2011	(345/588) 58.7%	(5.7/53.0%) 10.8%
Mental health Openness Scale	April 2010	(468/558) 83.9%	Increase by 3%	Media Campaign, September 2010-Current	March 2011	(485/560) 86.6%	(2.7/83.9%) 3.2%
Mental Health Knowledge & Access Scale	April 2010	(255/538) 47.4%	Increase by 5%	Media Campaign, September 2010-Current	March 2011	(247/551) 44.8%	(2.6/47.4%) -5.5%

See Appendix B for within group comparisons.

For the two literacy scales (Mental Health Literacy, and Mental Health Knowledge & Access), the baseline measurement is the proportion of participants at baseline who correctly answered each item within that scale. For the two stigma scales (Lack of Social Distancing, and Mental Health Openness), the baseline measurement is the proportion of participants at baseline who selected the non-stigmatizing response for each item within that scale. The re-measurement results represent the same statistic for participants in the follow-up study.

"Was the PIP successful?" What are the outcomes?

17. Describe issues associated with data analysis:

a. Data cycles clearly identify when measurements occur.

Measurements occurred 6 months prior to the campaign launch, 6 months after the campaign launch, and will continue each subsequent year. This way, public knowledge and attitudes will be assessed at regular intervals for the course of the media campaign.

b. Statistical significance

At each measurement, data is collected for approximately 600 participants. This allows us to have enough power to observe the effects of the media campaign, and compare findings within subpopulations that stakeholders determined to be of special interest.

c. Are there any factors that influence comparability of the initial and repeat measures?

At the baseline measurement in April 2010, there were no specific questions related to the content of the media campaign, which had not yet been implemented. These items were added to subsequent surveys, but cannot be compared to baseline measures of exposure. It is possible that participants falsely remembered seeing campaign ads after being prompted, however this cannot be assessed without the baseline measure.

d. Are there any factors that threaten the internal or the external validity?

As with any voluntary survey, people with more positive attitudes towards the subject are more likely to agree to complete the survey. In this study, this might cause the results to be biased towards less mental health stigma and greater literacy than would be found in the overall population. Additionally, people who are more aware of mental health issues might be more inclined to watch the campaign spots carefully, or to remember them. Other events or advertising not related to the media campaign may have impacted participants' perceptions of mental illness, such as:

- Other San Diego County Prevention and Early Intervention programs, which are intended to decrease mental health stigma, and increase literacy. The results presented in this PIP could be partially due to these other projects.

- Advertising from drug companies, which could increase the mental health literacy of the general population, or make them more aware of the causes of specific disorders.
- Events in the media, such as the portrayal of Gabrielle Giffords' shooter, Jared Laughner, as schizophrenic, could alter people's perception of mental illnesses or encourage them to seek additional information on their own.

18. To what extent was the PIP successful? Describe any follow-up activities and their success.

The media campaign was primarily focused on interpersonal stigma, and encouraged help-seeking behavior. Improvement goals in this area were met as seen from the scores on the two mental health stigma scales (Table D): Lack of Social Distancing, and Mental Health Openness. This indicated that the campaign effectively targeted its message to residents of San Diego County. The other two improvement goals outlined in Table B were not met. Scores on the Mental Health Literacy scale showed a 3% improvement, which is less than the 10% improvement goal. Items in this scale addressed knowledge about mental health, its causes, diagnostic criteria, and treatment options. Several of these topics were touched on in the campaign, which could explain the slight increase. These areas were not the primary focus of the campaign, so a greater increase was not expected over this period.

Scores on the Mental Health Knowledge & Access scale were 5.5% lower at the follow up measurement. Items on this scale measured knowledge of community resources, and recognition of warning signs of various mental health problems. The primary message of the media campaign was to reach out for help by calling an access and crisis line, or visiting a website for more information. Due to the 30-second time constraint of the spots, these campaign materials did not present information about mental health diagnosis criteria or referrals. The decrease in this statistic could be a side-effect of an overall increase in awareness of mental illness. As people became more aware, they may have realized that they didn't know as much as they previously thought. This could be a benefit if it encourages people to seek information about available resources and warning signs. Following the original campaign plan, subsequent spots are being designed to address the warning signs of suicide, and other more specific mental health issues. Future follow-up surveys will assess how these scale scores change as their content becomes the focus of the campaign.

Despite the overall decrease in scores on the Mental Health Knowledge & Access scale from Wave I to Wave II, when looking at data from Wave II alone, scale scores were significantly higher for participants who had previously seen at least one campaign spot than they were for participants who had not been exposed to the media campaign (see Appendix B, Graph 1).

Overall, the media campaign has demonstrated success. In addition to exposing more than half of San Diegans to positive messages about mental health, the campaign has been positively received by residents. In direct exposure studies, participants reported that the campaign materials increased their knowledge and made them more likely to be supportive of people with mental illnesses. Additionally, more objective findings have shown that residents who have seen the campaign materials are more willing to be socially involved with people with mental illnesses, and more open to offering help and seeking treatment. Increases in calls to the Access and Crisis Lines following airings of the media spots demonstrates that

people are in fact seeking help for themselves or others as a result of the media campaign. These are essential first steps in reducing stigma and increasing appropriate treatment for mental illness. These preliminary results were used to outline the future direction of the media campaign. New messages and activities have been implemented and will be assessed using the March 2012 data collection.

19. Describe how the methodology used at baseline measurement was the same methodology used when the measurement was repeated. Were there any modifications based upon the results?

Methodology used at the baseline measurement and follow-up measurement were almost identical. The Random Digit Dialing survey was conducted by Strata using the same randomization and interview technique. There were a few additional items on the follow-up survey that related to the specific materials presented as part of the media campaign. At baseline, data analysis consisted primarily of descriptive statistics, and between group comparisons for the stakeholder-identified groups of interest. Descriptive statistics were also completed after the follow-up survey, however additional independent samples t-tests and χ^2 tests were conducted to compare the results from the follow-up to the baseline study.

20. Does data analysis demonstrate an improvement in processes or client outcomes?

Mental health stigma is a broad sentiment that is deeply ingrained within the population. Prior to implementing the campaign, the advertising agencies involved planned on distributing a variety of messages throughout the campaign to specifically target different aspects of mental health stigma, and to address different areas of literacy. The process was designed to be flexible so that messages could be directed towards areas of deficiency found through the data analysis process. So far, this method has proved successful. San Diego residents appear to be responding well to the campaign ads, and were more likely to be aware of mental health resources and seek treatment at the follow-up than they were at baseline.

21. Describe the “face validity” – how the improvement appears to be the result of the PIP intervention(s).

There were several significant differences between responses on the follow-up survey for participants who had and had not seen the Up2SD television spots. For example, participants who had seen the campaign:

- Were more comfortable talking to a friend of family member about their mental health (χ^2=2.946, *p*=.086);
- Were more likely to know of community mental health resources (χ^2=3.756, *p*=.053); and
- Were more likely to know how to recognize warning signs for suicide (χ^2=3.415, *p*=.065).

As a result of the ads, respondents felt that they were:

- More likely to be supportive of someone experiencing mental illness (85%);
- More likely to treat others with mental illness with respect (84%); and
- More likely to feel comfortable talking to a friend or family member about their mental illness (74%).

Compared to Wave I, in Wave II a significantly larger proportion of respondents reported that if they were suffering from a mental illness they would seek help from: family or friends (66% vs. 52%), a medical doctor (81% vs. 70%), a counselor or psychologist (80% vs. 69%), a crisis line (52% vs. 37%), a spiritual leader (42% vs. 32%), a website (37% vs. 28%), or an employer (2% vs. 0%). Additionally, participants who had seen more than one spot scored significantly higher than those who only saw one spot on three of the four mental health scales – Mental Health Knowledge & Access, Lack of Social Distancing, and Mental Health Literacy. Participants who saw all four spots scored significantly higher than those who saw fewer ads on the Mental Health Openness scale. Previous advertising research has shown a similar pattern in the influence of media campaigns, with greater exposure leading to more significant recognition and influence.

22. Describe statistical evidence that supports that the improvement is true improvement.

Throughout the surveys conducted by Strata and HSRC, participants were asked questions related to mental health treatment, stigma, and literacy in a variety of contexts, and with differing levels of emotional connection (i.e. some related to personal treatment history, others related to whether a fictional character should seek treatment). Responses across different types of questions seemed to converge to lead to the same conclusions. For example, participants who had seen campaign ads scored higher on the Mental Health Knowledge & Access and Lack of Social Distancing scales. This indicates that these participants are more knowledgeable about the causes and treatment of mental illness, better able to recognize signs of mental illness, more aware of local resources, and more likely to accept and be supportive of someone with a mental illness. After listening to the spots in the direct exposure portion of the study, a majority of respondents felt that the spots increased their mental health knowledge and positively changed their attitudes towards mental illness (see table on page 13).

On a more personal level, respondents who recognized at least one campaign ad in the direct exposure study were significantly more likely to report having ever received treatment than those who did not recognize any of the ads (χ^2=4.101, p=.043). These respondents were also more likely to report having thought about seeking help in the past 6 months (χ^2=3.802, p=.051) and to report actually seeking help in the past 6 months (χ^2=3.498, p=.061). Increased reports of mental health treatment could be due to:

- Increased number of people receiving services in the community due to:
  - Increased knowledge of available services
  - Increased knowledge of the causes of mental illness and treatment efficacy
  - Reduced stigma
- Increased reporting rates (same number of people receiving services) due to:
  - Increased knowledge of the causes of mental illness
  - Increased openness, an indication of reduced stigma within the community

23. Was the improvement sustained over repeated measurements over comparable time periods?

Additional measurements will be conducted annually beginning in March 2012, one year after the follow-up study (18 months after the campaign launch). We will continue to measure changes over time.

Appendix A – Strata survey items

Participants in the study were read the explanation below, followed by a short vignette about a character named either John or Mary (or Juan/Maria for Spanish-speaking participants) who was suffering from either schizophrenia or depression. Interviewers were instructed to select the correct name and disorder when reading the items that contained brackets. The percentage of respondents who selected each response is detailed in the table below.

"I'm going to read you some statements about [John's/Mary's] situation and I would like you to tell me how MUCH you agree or disagree with each of them with 4 being a strongly agree, a 3 being you agree, a 2 being you disagree, and 1 is strongly disagree. Would you like to write this scale down since most of my questions will use this?"

	Strongly Agree	Agree	Disagree	Strongly Disagree
Lack of Social Distancing				
I would be willing to have [John/Mary] as a neighbor.	21.0%	57.6%	16.4%	5.0%
I would be willing to spend time socializing with [John/Mary].	17.2%	60.0%	18.7%	4.2%
I would be willing to work closely with [John/Mary] on a job.	10.5%	56.4%	26.8%	6.4%
I would be willing to have [John/Mary] marry someone in my family.	5.1%	32.1%	42.1%	20.7%
* Being around [John/Mary] would make me feel nervous or uncomfortable.	5.2%	27.5%	47.9%	19.4%
* People with mental health problems are more likely than others to be dangerous.	9.1%	39.0%	40.4%	11.5%
People like [John/Mary] are just as productive as others.	8.8%	39.1%	40.4%	11.8%
[John/Mary] should be hired just like other people.	16.2%	48.7%	29.1%	6.1%
* People like [John/Mary] shouldn't be allowed to care for children.	14.0%	33.4%	36.7%	15.9%
Mental Health Openness				
* [John/Mary] would lose friends if people knew about [his/her] mental health problems.	8.2%	38.5%	41.8%	11.5%
* [John's/Mary's] family would be better off keeping [his/her] problem a secret.	4.2%	6.7%	36.5%	52.7%

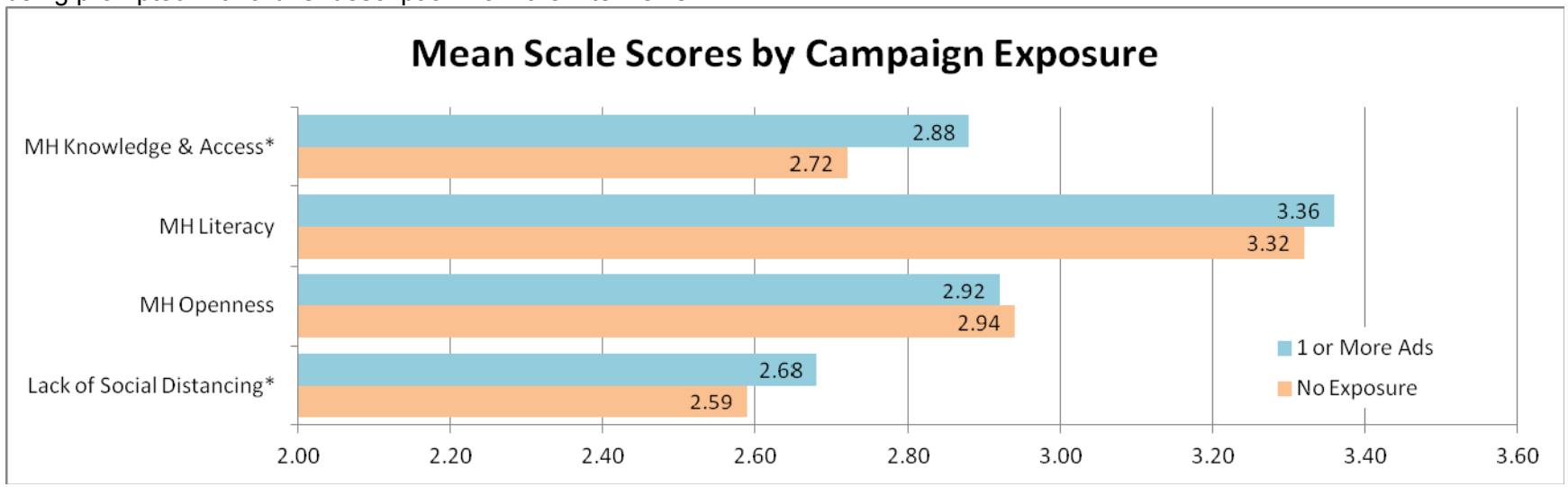
	Strongly Agree	Agree	Disagree	Strongly Disagree
* I would be afraid to tell people about my situation if I had mental health problems.	8.3%	36.2%	39.2%	16.3%
Mental Health Literacy				
It's likely that [John's/Mary's] situation will improve with treatment.	41.9%	50.2%	5.5%	2.3%
It's likely that [John/Mary] is experiencing mental illness.	38.3%	41.5%	17.0%	3.2%
It's likely that [John/Mary] is experiencing [schizophrenia/ depression].	48.7%	36.9%	10.8%	3.6%
* It's likely that [John's/Mary's] situation is caused by bad character.	2.7%	11.1%	35.8%	50.4%
Mental health is as important as physical health.	69.9%	27.6%	1.2%	1.3%
I feel sympathy for people with mental health problems.	45.3%	48.8%	4.0%	1.8%
I would be comfortable talking to a friend or family member about their mental health.	35.2%	53.7%	8.7%	2.5%
I would attempt to get help for myself if I was having mental health problems.	51.9%	41.8%	4.5%	1.8%
I believe that suicide is preventable.	38.4%	54.5%	4.8%	2.4%
I believe that mental health issues are common.	28.2%	58.2%	12.6%	1.0%
Mental Health Knowledge & Access				
My community has resources for mental health problems that are easy to access and understand.	14.0%	46.2%	30.9%	8.8%
I know how to recognize the warning signs of suicide in other people.	14.5%	43.9%	34.4%	7.3%
I know where to get help if I saw someone in my family showing warning signs of suicide.	35.0%	45.9%	14.3%	4.9%
I know how to recognize emotional or behavioral problems in children.	17.6%	55.2%	24.0%	3.2%
I know where to seek help in my community for emotional or behavioral problems in children.	21.9%	44.5%	23.1%	10.5%

* These items were reverse scored.

Appendix B – Participant Scores on Mental Health Scales

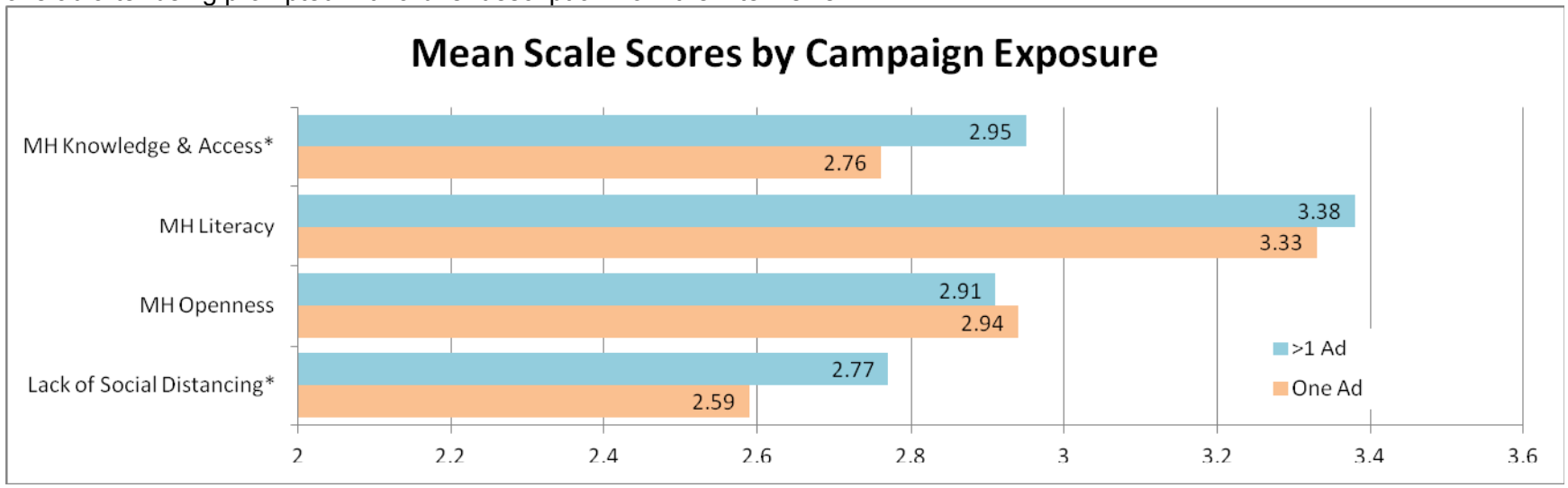
The graphs below depict the between group differences in mean scale scores.

Graph 1. Mean scale scores for participants who recognized, and did not recognize at least one of the media campaign ads after being prompted with a brief description from the interviewer.



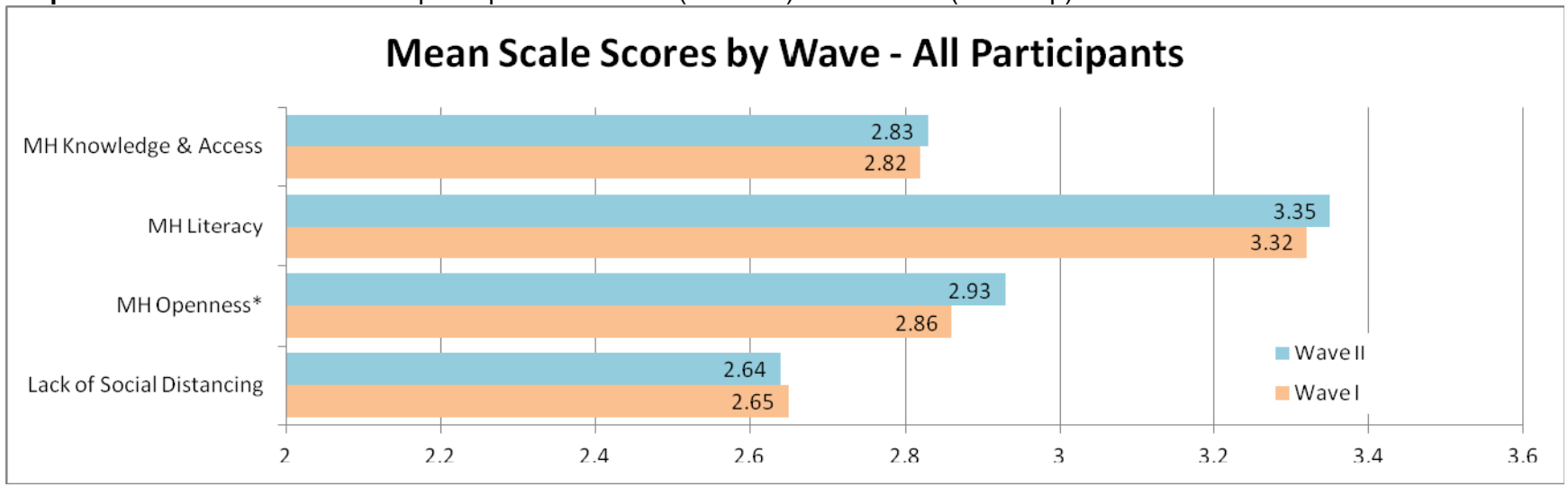
* Difference was significant at the 0.1 level.

Graph 2. Mean scale scores for participants who recognized one of media campaign ads versus those who recognized more than one ad after being prompted with a brief description from the interviewer.



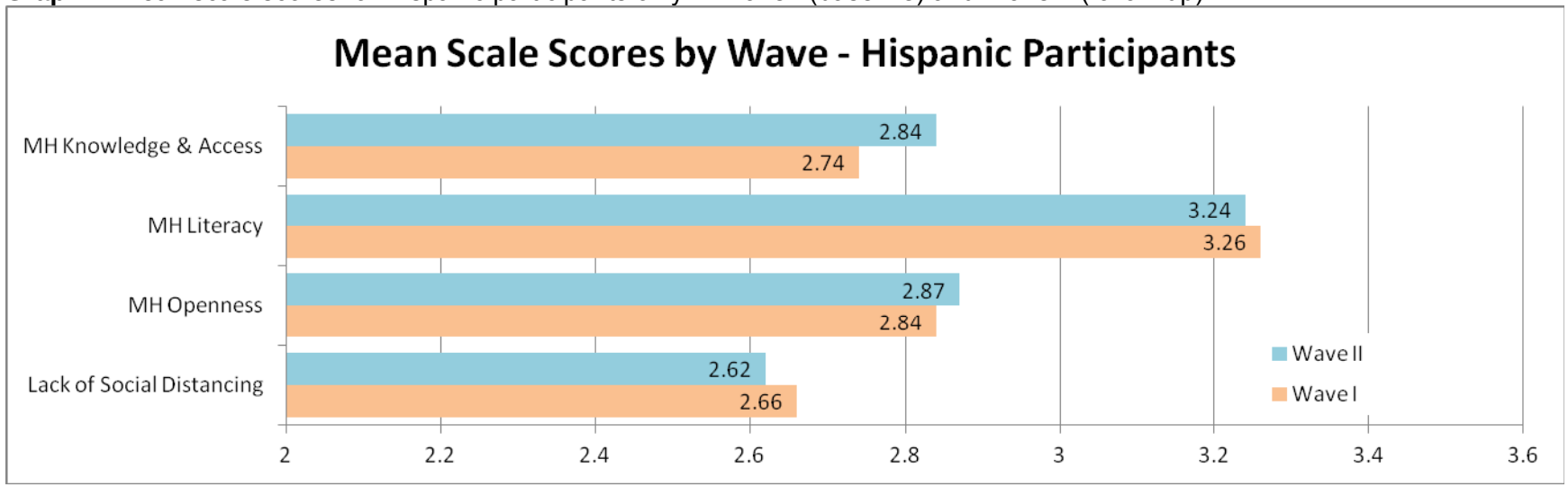
*Difference was significant at the 0.01 level.

Graph 3. Mean scale scores for all participants in Wave I (baseline) and Wave II (follow-up).

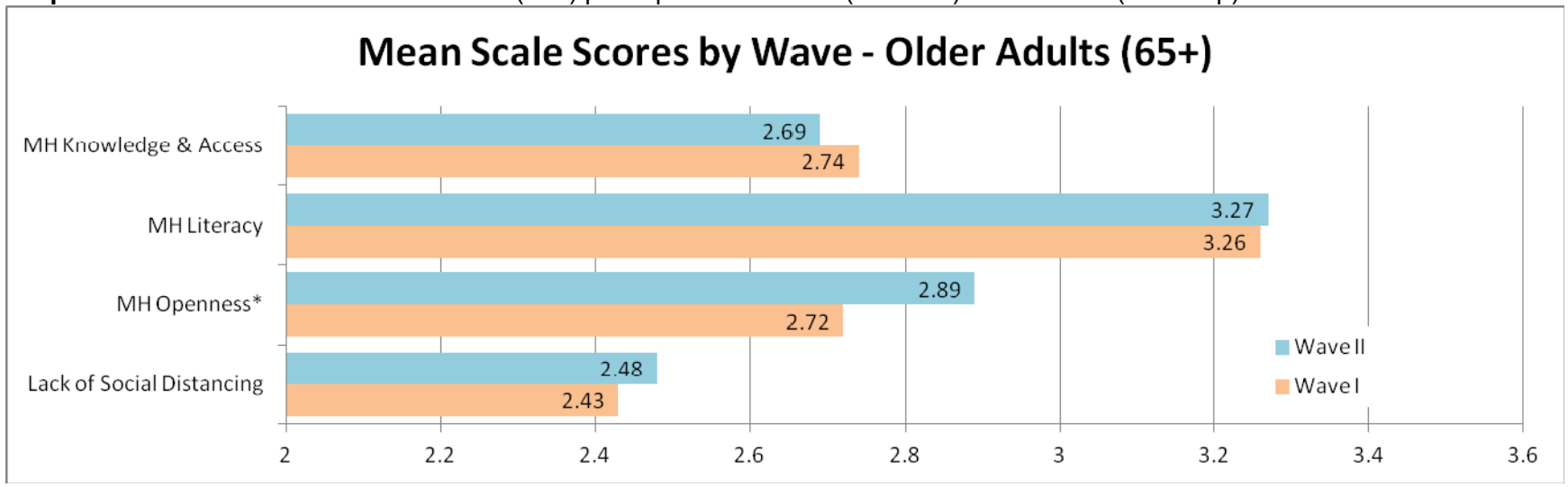


*Difference was significant at the 0.01 level.

Graph 4. Mean scale scores for Hispanic participants only in Wave I (baseline) and Wave II (follow-up).



Graph 5. Mean scale scores for older adult (65+) participants in Wave I (baseline) and Wave II (follow-up).



*Difference was significant at the 0.01 level.

Graph 6. Mean scale scores for transition aged youth (18-24) participants in Wave I (baseline) and Wave II (follow-up).